ILLINOIS CHILD DEATH REVIEW TEAMS:
A PARTNERSHIP FOR PROTECTING CHILDREN

ANNUAL REPORT

ON CHILD DEATHS THAT OCCURRED IN CALENDAR YEAR 2013

MISSION

To reduce preventable child fatalities and serious injuries among Illinois children.

Illinois Department of DCFS Children & Family Services

SUBMITTED TO:

The Honorable Bruce Rauner,
Governor, State of Illinois

Illinois State Senate

Illinois House of Representatives

JANUARY 2015

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January 2015

The Honorable Bruce Rauner, Governor of the State of Illinois:
The Honorable Members of the 99th General Assembly:

It is our privilege to submit the Illinois Child Death Review Teams Annual Report for 2013. In accordance with Public Act 88-614, nine Illinois Child Death Review Teams (CDRT) review deaths of children under the age of eighteen years. All of the deaths that are reviewed are children who have been involved within a year of their death with the Department of Children and Family Services (DCFS) and/or died unexpectedly or without explanation.

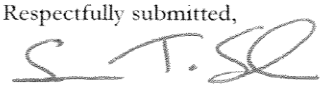
The Child Death Review Teams' goal is to learn from children's deaths in Illinois in order to prevent unnecessary deaths of other children. Each team makes recommendations that range from public awareness campaigns to requesting implementation of new policies for state agencies including the Department of Children and Family Services (DCFS). The CDRT Executive Council reviews all recommendations made by the nine Illinois Child Death Review Teams and submits them to DCFS. The CDRT Executive Council continues to value the time the Director of DCFS dedicates to meet with the Executive Council, in-person, to discuss the recommendations made by the child death review teams, the responses given by DCFS to these recommendations, and the implementation of these recommendations.

We want to thank DCFS Acting Director Bobbie Gregg for agreeing to meet with the CDRT Executive Council in person and continuing to work with child death review. We truly appreciate all of your extra time and efforts. We would also like to thank all of the DCFS staff that is currently working with child death review. Thank you for your cooperation and for providing the necessary resources for the nine Child Death Review Teams and the Executive Council.

We would also like to express our sincere appreciation to the almost two hundred professionals of multiple disciplines who are the members of the nine CDRTs. Thank you for volunteering your time, your expertise, and your experiences to this very important effort. A special thanks goes to our fellow members of the Executive Council who not only serve as the Chairpersons and Vice Chairpersons of their individual teams, but who also attend additional meetings to finalize teams' recommendations and discuss general child death review issues. All of you are invaluable to this process of protecting Illinois' children.

Lastly, we thank Governor Rauner and the members of the General Assembly for the opportunity to protect and serve the welfare of the children of Illinois.

Respectfully submitted,



Lawrence T. Solava
Chairperson, Executive Council
Illinois Child Death Review Teams

Bruce Rauner
Governor

Illinois Department of
DCFS
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Cynthia L. Tate, Ph.D.
Interim Director

Dear Readers,

It is my commission to present the 2015 Illinois Child Death Review Teams Annual Report. The information in the report includes the data for the child deaths that occurred during calendar year 2013.

In Illinois, The Child Death Review Teams (CDRT) play an important role in the effort to reduce preventable child deaths. Since 1994, CDRT and the CDRT Executive Council have made hundreds of recommendations to the Department of Children and Family Services and DCFS takes these recommendations very seriously for it is committed to better protect the children of Illinois.

The child death review process is an example of all of us sharing the responsibility of advocating for children who otherwise would not have a voice. This process is only possible because of the commitment and support of hundreds of caring professionals across the state who volunteer their time and expertise to review and discuss prevention strategies to reduce child injury and death.

A big thank you to the CDRT for their efforts and we look forward to working with these dedicated individuals in the near future.

Sincerely,

Cynthia L. Tate, Ph.D.
Illinois DCFS

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ACKNOWLEDGEMENTS

This report would not be possible without the dedication and unwavering support of almost 200 experts throughout Illinois who volunteer their time to serve on the Child Death Review Teams. Members of the Child Death Review Team Executive Council have provided additional time and knowledge to guide and support the child death review process in Illinois.

The production of this report represents the ongoing collaboration between the Illinois CDRT Executive Council, the Illinois Department of Children and Family Services, and the Children and Family Research Center at the University of Illinois at Urbana-Champaign.

Illinois Child Death Review Teams staff Tamara Skube, Bernadette Emery, and Sherry Barr provided the data from the Child Death Review Team database and suggestions to Dr. Saijun Zhang. Children and Family Research Center staff Dr. Saijun Zhang and Dr. Tamara Fuller wrote the report.

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EXECUTIVE SUMMARY

Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The primary goals of the Child Death Review Teams (CDRTs) are 1) to review the circumstances of child fatalities in order to gain a better understanding of their causes and 2) to recommend changes in practice and policy that will *prevent* future injuries and deaths.

Illinois Child Deaths in 2013

In 2013, 1,503 children under 18 died in Illinois[1]. This number represents the death information received by CDRTs.

Of the total child deaths reported to DCFS in 2013:

- 57% were boys and 43% were girls;
- 64% were infants under one year, 10% were young children between 1 and 4 years, 14% were older children between 5 and 14 years, and 13% were youth between 15 and 17 years[2].

When Illinois child deaths in 2013 were examined by the manner of death:

- 69% were attributable to natural causes;
- 12% were accidental;
- 8% were homicides;
- 3% were suicides;
- 9% were undetermined.

When deaths occurring in 2013 were examined by the category of death:

- 35% were related to illness;
- 33% were related to premature birth;
- Less than 1% were related to Sudden Infant Death Syndrome (SIDS) and 2% were related to other types of unknown infant deaths;
- 24% were related to various types of injuries, such as suffocations (7%), firearms (6%), vehicular accidents (4%), drowning (2%), fires (1%), and other types of injuries (4%);
- 5% were due to undetermined causes.

[1] The Illinois Department of Public Health reports all death data to the Enterprise Data Warehouse that is managed by Healthcare and Family Services (HFS). The data accessed by DCFS is preliminary and has not been processed through the Illinois Department of Public Health quality control. The total number of child deaths is based on the death information that DCFS received from HFS as of 9/24/2014.
[2] Due to rounding, some percentages in the report may not add up to 100%.

2013 Child Deaths Reviewed by the CDRTs

In 2013, 163 child deaths were reviewed by the CDRTs, including 159 mandatory and 4 discretionary reviews. The mandatory reviews occurred for one of several reasons: 109 were indicated death cases, 21 were indicated investigations, 26 cases had an investigation in the year before the child's death, 1 involved an open DCFS investigation at the time of death and 2 were open DCFS cases.

Reviewed deaths in 2013 occurred in all CDRTs regions (see Appendix A for the CDRT regional map), although there were regional differences in the percentages of child deaths that were mandated for review:

- Aurora – 20 of the 215 deaths (9%) were reviewed.
- Champaign – 14 of the 88 (16%) were reviewed.
- Cook – 67 of the 775 (9%) were reviewed.
- East St. Louis – 17 of the 43 deaths (40%) were reviewed.
- Marion – 9 of the 61 deaths (15%) were reviewed.
- Peoria – 13 of the 112 deaths (12%) were reviewed.
- Rockford – 7 of the 55 deaths (13%) were reviewed.
- Springfield – 14 of the 73 deaths (19%) were reviewed.
- In addition, 2 of 81 deaths (2%) that were out of state were reviewed.

Of the deaths reviewed by CDRTs in 2013:

- 58% were boys and 42% were girls;
- 61% were infants under one, 20% were young children between 1 and 4 years, 13% were older children between 5 and 14 years, and 6% were youth between 15 and 17 years.

When reviewed deaths occurring in 2013 were examined by manner of death:

- 34% were attributed to accidents;
- 13% were due to natural causes;
- 20% were homicides;
- 1% were suicides;
- 33% were undetermined.

When reviewed deaths occurring in 2013 were examined by category of death:

- 12% were related to illness;
- 4% were related to premature birth;
- 1% were related to Sudden Infant Death Syndrome (SIDS) and 4% were related to other types of unknown infant deaths;
- 61% were related to various types of injuries, such as suffocations (31%), injuries (14%), vehicular accidents (6%), drowning (6%), firearms (2%), and poisoning/overdose (1%);
- 18% were due to undetermined causes.

Introduction

The death of a child is always a tragic event. Although there have been improvements in public health such as basic medical care, immunizations, and safety policies that have led to a decline in infant and child mortality, too many Illinois children are still dying. In 2013 there were 1,503 child deaths. Many of these deaths were preventable.

Nine regional Child Death Review Teams (CDRTs) were established by Illinois statute in 1994 and implemented throughout the state in 1995 in an effort to better understand the reasons for child deaths. In 1999, the CDRTs produced the first annual report summarizing team findings and presenting recommendations for reducing preventable child deaths. The CDRT annual report is presented to the Governor, the Illinois Legislature, and other interested parties in a continued effort to understand and reduce preventable child deaths in Illinois.

Since the implementation of the child death review process, individuals and agencies responding to child deaths have come to understand the importance of a coordinated, multi-agency response. Recommendations from the CDRTs have helped to develop, streamline, and implement better practices regarding child safety.

This report honors the memory of all children who have died in Illinois. The Child Death Review Teams present this report in the hopes of furthering understanding of how we can make Illinois a safer and healthier state for children.

Chapter 1: Child Death Review in Illinois

In response to the national movement to reduce preventable child deaths, Illinois established multidisciplinary and multi-agency child death review teams throughout the state with the Illinois Child Death Review Team Act (P.A. 88-614), which was signed into law September 7, 1994. The act was amended by P.A. 90-239 on July 28, 1998 and more recently by P.A. 95-0405 on August 24, 2007 and P.A. 95-0527 on August 28, 2007.[3] Prior to this time, child death cases were examined only by the Cook County Child Fatality and Serious Injury Review Committee. This Committee, in conjunction with the Illinois Child Fatality Task Force, provided the guidance, impetus and technical expertise to establish the statewide child fatality review process delineated in the Child Death Review Team Act.

The Illinois Child Death Review Team Act created a partnership among many agencies, organizations, and professionals across the state that serve and advocate for children. In particular, it established a strong working relationship between the Child Death Review Teams (CDRTs) and the Illinois Department of Children and Family Services (DCFS) Division of Child Protection.

Child Death Review Team Composition

The composition of CDRTs and the process for selecting members is outlined in the Child Death Review Team Act. There are nine child death review teams in Illinois, one in each of the seven DCFS administrative sub-regions outside Cook County and two within Cook County. A map of the CDRTs sub-regions is located in Appendix A.

The Child Death Review Team Act requires that each CDRT includes at least one member from each of the following disciplines:

- Pediatrician or other physician knowledgeable about child abuse and neglect,
- Representative from DCFS,
- State's attorney or state's attorney's representative,
- Representative of a local law enforcement agency,
- Psychologist or psychiatrist,
- Representative of a local health department,
- Representative of a school district or other education or child care interests,
- Coroner or forensic pathologist,
- Representative of a child welfare agency or child advocacy organization,
- Representative of a local hospital, trauma center, or provider of emergency medical services, and
- Representative of the Department of State Police.

[3] The complete Act is available online at http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=244&ChapterID=5.

Teams may make recommendations to the DCFS Director concerning additional professionals to serve on their team as needed. Team members, who are volunteers, are appointed to the team for two years and are eligible for reappointment upon expiration of their term. The Director must fill any vacancy in a team within 60 days after the vacancy occurs. Each team elects a Chairperson and Vice-chairperson from their members. For a list of all members of regional CDRTs see Appendix B.

Child Death Review Team Executive Council

The CDRT Executive Council is the coordinating and oversight body for child death review activities in Illinois. It consists of the chairpersons and vice-chairpersons of each of the nine CDRTs. The Executive Council meets quarterly to review the procedures common to the examination of child deaths throughout the state. According to P.A. 92-0468 (effective August 2002), Executive Council responsibilities include, but are not limited to:

- serving as the voice of child death review in Illinois;
- providing oversight of regional CDRTs to ensure that their work is coordinated and in compliance with legislation and the operating protocol;
- ensuring that the data, results, findings, and recommendations of the teams are adequately used to make necessary changes in the policies, procedures, and statutes in order to protect children;
- collaborating with the Illinois General Assembly, DCFS, and others in order to develop legislation needed to prevent child fatalities and protect children;
- assisting in the development of quarterly and annual reports based on the work and the findings of the CDRTs;
- ensuring that the review processes of regional teams are standardized in order to convey data, findings, and recommendations in a usable format;
- serving as a link with CDRTs throughout the country and participate in national child death review team activities;
- developing an annual statewide symposium to update the knowledge and skills of CDRT members and to promote the exchange of information between teams;
- serving as a sub-committee of the DCFS Citizen's Review Panel;
- providing the CDRTs with the most current information and practices concerning child death review and related topics; and
- performing any other functions necessary to enhance the capability of the child death review teams to reduce and prevent child injuries and fatalities.

During 2014, the Illinois Child Death Review Teams (CDRT) accomplished several goals including the following:

- In collaboration with the Children and Family Research Center at the University of Illinois at Urbana-Champaign, the Illinois Child Death Review Teams Annual Report for 2013 was written and printed.

- Monthly meetings of the Executive Council were held to review regional team recommendations and bi-monthly meetings with the Director of the Department of Children and Family Services (DCFS) were held to discuss team recommendations on specific cases to determine if DCFS policy or procedures will be revised or new policies or procedures will be developed.

- Executive Council updated their by-laws as well as the Illinois Child Death Review Teams Protocol and Best Practices for the Multidisciplinary Review of Child Deaths in August 2014.

- The 18th Annual Child Death Review Teams Symposium was held April 24-25, 2014 at the Hilton in Springfield. The presentations included: 1) A Little Time Makes a Big Difference by R. Dale Evans Sr.; 2) Making Sense of the SIDS/SUDI/SUID/Undetermined Quagmire by Dr. Eric Eason, Cook County Assistant Medical Examiner; 3) Crisis Intervention in Fatal Child Abuse Cases by Susanne Walters; 4) East St. Louis case specific presentation by Derek Hobson, DCFS, Dr. Daniel J. Cuneo, Chairperson of the Executive Council, and Carole Presson, Vice Chairperson of the East St. Louis Team. The symposium was well attended with over 80 members present.

DCFS Roles and Responsibilities

The Illinois DCFS Office of the Chief of Staff provides essential administrative support and assistance to the CDRTs (i.e., the CDRT Coordinator). In addition, the Department serves as a direct link between the review teams and the State's child protection policy makers. The Director of DCFS must review and reply to recommendations made by the CDRTs within 90 days of receipt.

Illinois Child Death Review Process

The Illinois child death review process is outlined in the CDRT *Protocol for the Multi-disciplinary Review of Child Deaths*. This protocol provides a practical manual for CDRT members and ensures comparability of CDRT reviews and findings among the teams by defining: 1) the types of cases to be reviewed, 2) the procedures used to review cases, and 3) the confidentiality parameters of review findings and recommendations.

Purpose of Child Death Review

The overarching mission of child death review is to reduce the number of preventable child deaths in Illinois. CDRTs achieve this goal by fulfilling the objectives stated below:

- Evaluate the means by which the death might have been prevented.
- Report findings and recommendations to appropriate agencies.
- Promote continuing education for professionals involved in investigating, treating, and preventing child abuse and neglect.
- Make specific recommendations to the Director and Inspector General of DCFS concerning the prevention of child deaths due to abuse or neglect and the establishment of protocols for investigating child deaths.

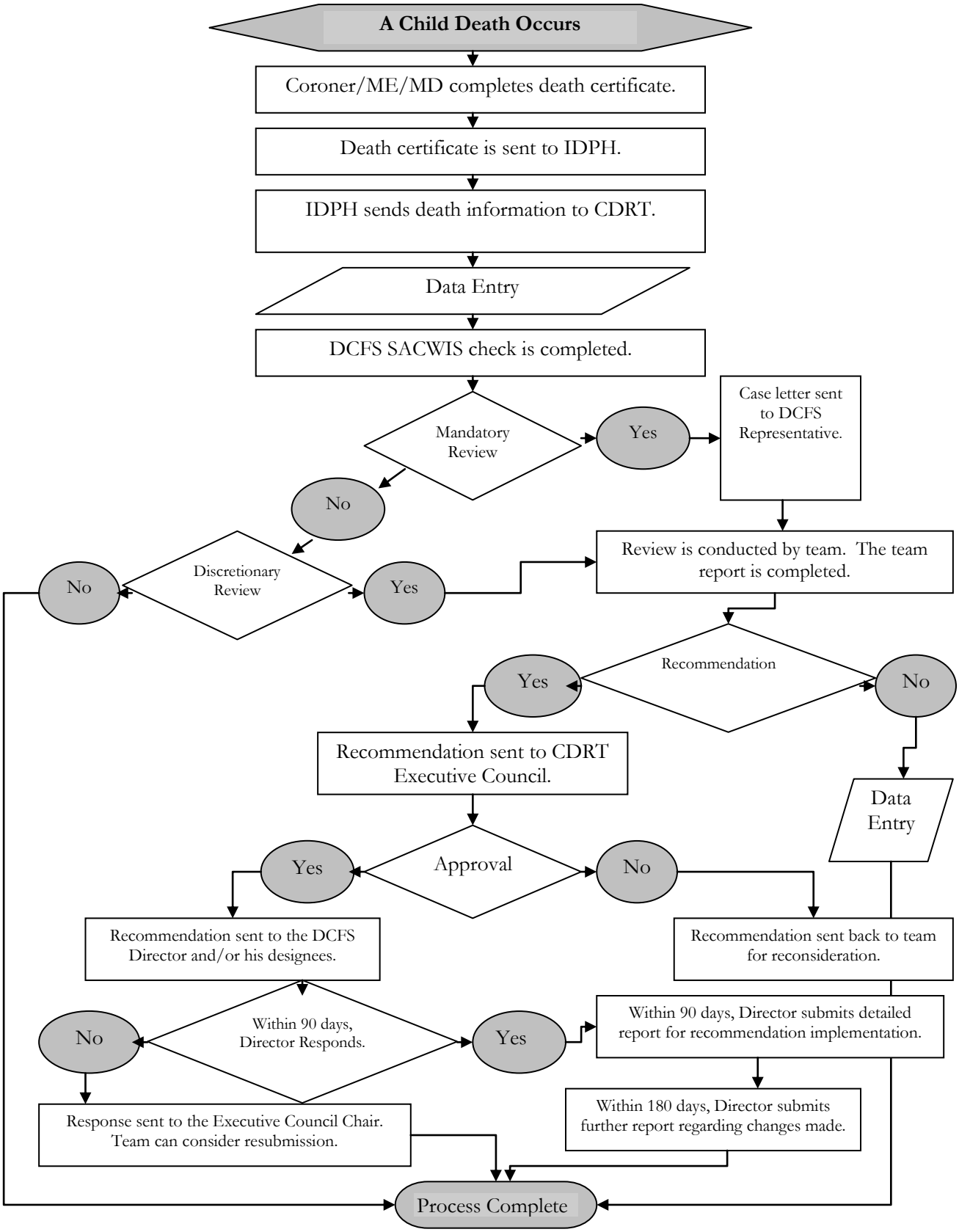
Other responsibilities of the CDRTs are to:

- assist in identifying systemic barriers that reduce the effectiveness of child welfare and child protective services;
- assist in increasing the effectiveness of public health services, prevention efforts, intervention services, and investigative and legal processes aimed at reducing child mortality;
- enhance and support cooperation and communication among agencies;
- share information about advances in the field of investigation, prevention, intervention, and prosecution regarding child maltreatment and child fatalities;
- contribute to initiatives to improve public awareness of issues that affect the safety and well-being of children;
- collect data that will inform efforts to reduce child fatalities; and
- keep the governor and legislature apprised of CDRT findings and recommendations and of legislation needed to reduce child fatalities and protect the lives of children.

The Child Death Review Team process is outlined in a flow chart in Figure 1.

Child Death Review Procedures

Figure 1: The Child Death Review Process in Illinois

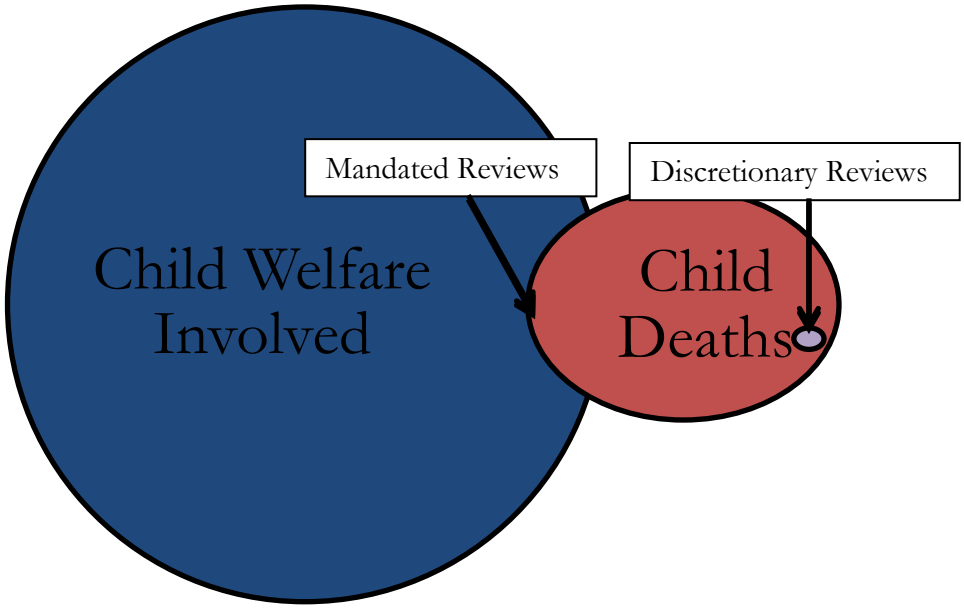


After a child's (age 17 or younger) death occurs, a coroner or medical examiner completes the death certificate online and electronically forwards the death certificate to the Illinois Department of Public Health (IDPH). IDPH electronically provides the Child Death Review Office with the information. The death information is added to the Child Death Review Database.

Once the death information is received by the Child Death Review Office, a search of the Statewide Automated Child Welfare Information System (SACWIS) for the child/family name is performed to identify those cases in which the child had prior involvement with DCFS. Child death review is required, or *mandated*, for all child deaths in which there was prior family involvement with DCFS within the prior year (see Figure 2). Specifically, CDRTs are required to review the deaths of all children aged 17 or younger if the deceased child was:

- a ward of DCFS,
- a non-ward, when death occurs in a licensed foster home,
- the subject of an open DCFS service case,
- the subject of a pending child abuse or neglect investigation,
- the subject of an abuse or neglect investigation during the preceding 12 months, and/or
- any other child whose death is reported to the Child Death Review Office as the result of indicated child abuse or neglect.

Figure 2: Child Death Reviews



CDRTs are also statutorily permitted to review any unexplained or unexpected death of a child under 18, as well as cases of serious or fatal injuries to a child identified under the

Child Advocacy Center Act.[4] These reviews are called discretionary reviews (Figure 2). Information from the death certificates received by the CDRTs is electronically entered into the CDRT database, as is information obtained from SACWIS regarding prior child or family involvement with DCFS within the year prior to death. If a child death review is mandated, a team report form is completed at the CDRT meeting.

According to the Child Death Review Team Act, reviews must be timely. Specifically, each CDRT shall meet at least once in each calendar quarter. In addition, the CDRT must review a case as soon as is practical and not later than 90 days following the completion of an investigation by DCFS. When there has been no investigation by DCFS, the CDRT must review the case within 90 days of obtaining the information necessary to complete the review from the coroner, pathologist, medical examiner, or law enforcement agency.

All CDRTs use the same report form to collect information, record findings, and list recommendations. This form details the circumstances of the child death. As a part of the child death review, a CDRT may submit recommendations to DCFS that are intended to prevent additional child fatalities through reasonable means. Recommendations are not always necessary in cases where the death was unpreventable through reasonable means or if no changes are needed to existing programs or practices.

After the Child Death Review Team Report is completed at the team meeting, the Child Death Review Office enters all information into the Child Death Review Database. All recommendations are sent to the Executive Council for approval. If the Executive Council approves a recommendation from a Team, this recommendation is presented to the Director of DCFS for review at the bi-monthly Director and Executive Council meeting. The Director must review and reply to recommendations (except case-specific) within 90 days of receipt. The Director shall submit his or her reply both to the chairperson of that team and to the chairperson of the Executive Council. The Director's reply to each recommendation must include a statement as to whether the Director intended to implement the recommendation.

CDRT Access to Information

According to the Child Death Review Team Act, DCFS personnel are required to provide the CDRTs with all records and information in their possession that are relevant to the team's review of a child's death, including information concerning previous DCFS investigations and information gained through the Child Advocacy Center protocol for cases of serious or fatal injuries. In addition, a CDRT has access to all records and information in the possession of a State or local agency that are relevant to the team's review of a child's death. This includes, but is not limited to, birth certificates, relevant medical and mental health records, law enforcement agency records, Department of

[4] In addition to mandated reviews and discretionary reviews, CDRTs are required to review child maltreatment reports under the following circumstances: If a mandated reporter makes a child abuse or neglect report to DCFS that is unfounded, they can appeal this finding and offer information that was present at the time of the initial report, but not considered. This information is reviewed during the appeal and a decision is made to follow-up on the report or to support the unfounded decision. If the unfounded decision is upheld, the mandated reporter may ask for a CDRT or other local multidisciplinary team to review the report. The team will review all pertinent information and make a recommendation to DCFS. There were no reviews of this nature requested in 2013.

Correction parole records, probation and court services records, and social service agency records regarding services to the child or family.

Confidentiality of CDRT Information

To ensure the confidentiality of the CDRT process, the Child Death Review Team Act mandates that information provided to and maintained by a CDRT is not subject to the Freedom of Information Act. In addition, these records are not subject to discovery or subpoena, and are not admissible in any civil or criminal proceeding. CDRT members cannot be subject to examination in any civil or criminal proceeding regarding information presented to members at a meeting or opinions shared in CDRT discussions. Furthermore, members of a CDRT are indemnified and held harmless for acts, omissions, decisions, and other conduct arising out of the scope of their service on the team. Finally, CDRT meetings are exempt from the Open Meetings Act and therefore closed to the public.

In addition to these provisions outlined in the Child Death Review Team Act, guidelines for CDRT meetings ensure the confidentiality of the information reviewed. Each team member must sign a confidentiality statement at the time of his/her appointment. Only appointed members may regularly attend meetings; guests must be approved by the team chairperson and sign a confidentiality statement. No notes may be taken from the meeting or recorded by team members or non-members.

Chapter 2: Child Death Review Recommendations to Prevent Child Deaths

The purpose of CDRT recommendations is to prevent or reduce future child fatalities through reasonable means. The importance of CDRT recommendations – and their potential for preventing future child deaths – cannot be overstated. The Director of DCFS is required by the Child Death Review Act to respond to CDRT recommendations within 90 days.

There are four types of CDRT recommendations, although some recommendations will include elements of more than one type:

- Case-specific – immediate actions which must be taken on a specific child welfare case; usually related to siblings of the deceased or other children still in the home

- Primary prevention – focus on public awareness or public education issues (e.g., drowning prevention, firearm safety, seat belt/car seat campaigns)

- DCFS system – focus on the programs, policies, and procedures of DCFS (e.g., safety and risk assessment, foster parent training)

- Other agency/system – focus on agencies or systems outside the parameter of DCFS (e.g. public health, state's attorney's office)

There were 24 "system-level" recommendations made by the CDRTs on deaths occurring in 2013, almost all of which (23) focused on DCFS policy and procedures (see Table 1). The DCFS recommendations resulted from 4 types of reviews including: death indicated (16), indicated report at time of death (5), investigation within a year (1), and discretionary review (1). There was 1 primary prevention recommendation from an indicated death case that occurred in 2013.

There were 18 case-specific recommendations in 2013 (see Table 1). Eleven of the case-specific recommendations resulted from cases where death was indicated, 6 were from cases that had an indicated report at the time of death, and 1 was from a case that had an investigation in the year before the death.

Key:
PP = Primary Prevention recommendation
DCFS = DCFS recommendation
OS = Other System recommendation
CS = Case-specific recommendation

Table 1: 2013 Recommendations and Responses

	Recommendation	**Response**
DCFS-1	In cases of low priority allegations and there is a subsequent death, the death should be added to ensure that higher investigator standards are followed.	This is currently in policy. The Area Administrator met with the Supervisor regarding the current procedure on adding applicable allegations to investigations. This case was also used as a training tool at an All Staff Meeting.
DCFS-2	If there is an open intact or placement case and there are multiple investigations, a staffing shall be held to review the case with all professionals involved up to and including but not limited to law enforcement, State's Attorney's office, medical professionals and POS.	DCFS agrees. If there is an open intact or placement case and an investigation is occurring, DCP shall have a staffing with the appropriate parties. This will be included in Procedure 300.
DCFS-3	Since it is now well described in child abuse pediatric literature, DCFS should form an interdisciplinary panel to develop a protocol to address potential DCFS allegations of medical child abuse.	DCFS has Procedure 300 Appendix L Factitious Disorder By Proxy (Draft Procedure 300 Appendix L is titled Medical Child Abuse) that provides guidelines for investigating reports of abuse and neglect when the child's parent or caregiver is suspected of having this disorder. Draft Appendix L provides characteristics of medical child abuse, effects of medical child abuse as well as the investigative process. When medical child abuse is reported by a medical professional and the information provided does not meet the criteria for an existing allegation, SCR will take the report and assign Allegation #10/60, Substantial Risk of Physical Injury.

DCFS-4	Team requests DCFS create a way that hospitals can identify to DCFS "at risk parents" of newborns based upon active cases, prior terminations, or other criteria. This would allow hospitals to communicate with DCFS to determine if further action or services are required.	Under the Children and Family Services Act, the Abused and Neglected Child Reporting Act, or Child Care Act, DCFS does not have the statutory authority to create such a database.
DCFS-5	Team recommends that DCFS take unsafe sleeping deaths as investigations and follow the CDRT proposal for indicating these reports. Team recommends that DCFS create an allegation for unsafe sleeping deaths.	DCFS disagrees. DCFS has accepted and implemented the recommendation of the Office of the Inspector General. The Department will stay abreast of changes that occur on a national level. In addition, the Department is involved in COIIN - Collaborative Improvement and Innovation Network Committee that is focused on reducing the infant mortality rate in Illinois.
DCFS-6	Team recommends that DCFS notify the State's Attorney's office when it is notified of a substance exposed infant.	DCFS agrees and will add this to Procedure 300.
DCFS-7	If medical exams are done as part of a Forensic Interview or Child Advocacy Center investigation anywhere in Illinois, consent must be obtained to share all results with the multi-disciplinary team or similar personnel employed by the Child Advocacy Center.	DCFS and OIG attorneys will look at this. DCFS will get back to the Council.
DCFS-8	Any medical exam done as part of a Forensic Interview or Child Advocacy Center investigation anywhere in Illinois must include photographs of the child's injuries or suspected injuries. If this is not possible, a detailed body chart must be completed. If the medical facility does not have the ability to photograph the child's injuries or suspected injuries, the DCP investigator must do so and make the images part of the investigative file. The responsibility for	This is already in current practice.

	photography/body charting/documenting injuries is the responsibility of the medical professional and/or DCP investigator, not the CAC.	
DCFS-9	Any minor interviewed regarding suspected child abuse or neglect must be asked if they are, or have been, in counseling.	DCFS disagrees. Procedures are not that specific. Not every investigation is the same. DCFS did agree to look at what questions they ask, and what they are trained to ask. DCFS will look into this.
DCFS-10	DCFS personnel statewide should receive training on "military-style" discipline, including how to evaluate if the type, frequency, and severity of the discipline are problematic.	DCFS agrees. They will modify the training.
DCFS-11	During a death investigation when an infant should be wearing an apnea monitor, investigator should have the doctor who ordered the apnea monitor ask the apnea monitor company for their records on that monitor's use for relevant time periods.	DCFS agrees. DCP will request this information from the prescribing physician. If unable to attain the records, DCP will use Administrative Subpoena. This will be added to Procedure 300.
DCFS-12	When there is a report to the hotline on a medically complex child, if it is indicated, the case should be open for ongoing services.	DCFS Director will talk to the Bureau of Operations and have them look at standards to see if there is a gap.
DCFS-13	When there is a report to the hotline on a medically complex child, if it is indicated, the DCFS nurse should be notified.	Notification to the nurse is already in procedure. According to Procedure 302 Appendix O, when an alleged child victim of a report of medical neglect is identified by the Investigation Specialist as possibly having special health care needs, or a child with special health care needs is living in the home of an alleged perpetrator, the Investigation Specialist is required to refer the child for nursing consultation services no later than 48 hours after case assignment. If the Investigation Specialist has not referred the

		child and an intact family services case is opened, the Intact Family Specialist must ensure that the child is referred to the Chief Nursing Services during the 45-day assessment period.
DCFS-14	Team requests DCFS gather data on how many death cases have had a previous unfounded allegation.	According to ANCRA, 325 ILCS 5/7.7, DCFS shall maintain in the central register for 3 years a listing of unfounded reports involving the death of a child, the sexual abuse of a child, or serious physical injury to a child as defined by the Department in rules. If an individual is the subject of a subsequent investigation that is pending, the Department shall maintain all prior unfounded reports pertaining to that individual until the pending investigation has been completed or for 12 months, whichever time period ends later. The Department shall maintain all other unfounded reports for 12 months following the date of the final finding. DCFS will respond to this.
DCFS-15	Team requests DCFS review their policy of not giving the State's Attorney's office information on unfounded previous investigations when screening a later investigation. If DCFS does not want to change this policy, team requests that DCFS report reasons to team.	DCFS will share previous unfounded investigations with the State's Attorney with the understanding that it cannot be used in any type of proceedings. We would need to change current Procedure 300 and 431. If reports are shared, any reporter identification information would be redacted.
DCFS-16	Team requests that DCFS complete an audit of DCFS cases that have gone to [Hospital X]. Team was concerned that the doctor would not document the bruises because he did not want to testify.	DCFS convened a meeting with Cook A Chairs and decided that Procedure 300 should be revised to address the issues identified in this case.

DCFS-17	Team requests DCFS look at the TA issue when a supervisor is on leave or not present. TA supervisor should know the case before signing off on it.	DCFS agrees with this recommendation. They will look into this. The details of this case were reviewed by the DCFS Regional Administrator. This case was used as a training tool with the investigator and supervisor involved as well as during an All Staff Meeting with investigation and supervisory staff. During the training session, emphasis was placed on adhering to all policies, assessing investigations for court intervention, making diligent efforts to contact fathers, and the importance of resolving guardianship issues.
DCFS-18	Providers with indicated investigations shall receive unannounced visits at least quarterly.	DCFS will explore this. They will look at staff ratios and will give a response at a later date.
DCFS-19	In death or serious injury investigations, DCFS should interview all parents about other children they have and get their names and birthdates. DCFS should get the names, birthdates and addresses of the caretakers the children are living with. DCFS should also request IDPH and IDHS conduct a due diligence record search for children of each parent and/or paramours in or out of the house. DCFS should assess the safety of all children.	DCFS agrees. The abuse and neglect of children at the hands of a perpetrator who is involved with another woman with a child, that child should be seen. This should be enhanced in Procedure 300.

DCFS-20	Team requests DCFS modify the portable crib release form to include that the family understands the importance of safe sleep and that they agree to use the crib and place the baby on its back.	DCFS does not have the authority to do this. Hospitals are already required to have parents sign a form that they received safe sleep information. Council discussed that when parents leave the hospital with a newborn, it is difficult for parents to remember everything they have been told. Council pointed out that DCFS has another opportunity for emphasizing safe sleep when DCFS provides a crib. DCFS agreed that they should emphasize safe sleep when they have the opportunity to do so. DCFS Director will go back and talk to DCP to see how difficult it would be to have them sign a different document that is not a legal document.
DCFS-21	Team recommends that DCFS change their current practice of not taking unsafe sleeping deaths as investigations. Team requests DCFS take unsafe sleeping death reports as investigations.	DCFS disagrees. The Department has accepted and implemented the recommendations of the Office of the Inspector General. The Department will stay abreast of changes that occur on a national level. In addition, the Department is involved in COIIN - Collaborative Improvement and Innovation Network Committee that is focused on reducing the infant mortality rate in IL.
DCFS-22	Team recommends that DCFS add an allegation to their allegation system for unsafe sleeping deaths when there are no drugs or alcohol involved. Allegation should be less than 50 years retention.	DCFS disagrees. The Department has accepted and implemented the recommendations of the Office of the Inspector General. The Department will stay abreast of changes that occur on a national level. In addition, the Department is involved in COIIN - Collaborative Improvement

		and Innovation Network Committee that is focused on reducing the infant mortality rate in IL.
DCFS-23	DCFS should re-evaluate the Dupuy appeal process and consider having a review of the administrator decision. The current process allows for a review of an indicated finding by an Administrative Law Judge but fails to allow for a review of an unfounded finding. This review should occur prior to the final finding.	DCFS disagrees. Dupuy is a federally mandated process and cannot be changed. The Department has the ability to delegate authority to the Area Administrator. After a review of this case it was determined that the Area Administrator should not have the case as unfounded based on the fact that there is a licensing issue. All Area Administrators were instructed to complete the Dupuy process based on evidence found during the investigation.
PP-1	Team recommends DHS place safe sleep labels on milk cans.	DCFS recommends that this request be taken to COIIN-Collaborative Improvement Innovation Network which is charged with developing strategies to reduce infant mortality.
CS-1	Team requests DCFS look at this case and how it was handled. The team is concerned that this case was closed prior to the final death certificate being completed. DCFS did not know this was ruled as a homicide and the cause of death was abusive closed head injury. Team was concerned that parents were not indicated for allegation 01.	This case was reviewed by the Regional Administrator and Area Administrator for Northern Region. The investigation was closed prematurely, prior to receiving the autopsy or report from the coroner. In addition, the worker did not indicate for allegation #1 Death by abuse. As a result of these findings, this case will be used as a training tool with the child protection workers and supervisors in Northern Region.

CS-2	Team requests DCFS look at how this case was handled by the POS agency. POS agency did not call DCFS hotline when the children were born. Why did the Judge give the case back to DCFS and DCFS did not realize that this needed to be done? Why didn't the POS agency screen the two youngest children?	DCFS agrees. A meeting was conducted with the Associate Deputy of Regulation and Performance and Children's Home and Aid Society Vice President to discuss the issues outlined in the case. As a result of the issues outlined in this case, two Program Directors and one supervisor were disciplined. The POS agency conducted an internal file review and has implemented a detailed quarterly peer record review process which will be conducted on approximately 20% of cases each year. The peer record review will specifically monitor the timely completion of UIR's, documented monthly supervision and the quality of the supervision note.
CS-3	Team requests DCFS look at this case and how it was handled. Team questioned why DCFS did not take protective custody of the new baby when DCFS had taken protective custody of 4 other children in this family as a result of an earlier investigation.	DCFS agrees. Procedure 300 does state a prior finding of unfitness regarding other children does not automatically mean subsequent children are neglected. The caseworker was reporting progress toward unsupervised visits at that time, so if that information was shared, SCR probably didn't find sufficient evidence for a new report. The POS agency should have screened both new babies with the State's attorney at time of birth; instead they attempted a hotline call in 2012 which was refused.
CS-4	Team requests that DCFS look at this case. Team was concerned because mom was not indicated for allegation 51. Team requests that DCFS use this case as a training tool.	DCFS disagrees. DCFS indicated the mother for allegation 60, substantial risk of physical injury/environment injurious to health and welfare because she was aware of paramour's past behaviors. However, DCFS did not feel that mom could have

		reasonably believed the paramour would have caused the death of his own infant son. There was no blatant disregard.
CS-5	Team recommends that a letter of commendation be sent to the investigator and supervisor for a job well done.	No response needed from DCFS.
CS-6	Team recommends that DCFS look at this case and how it was handled.	DCFS agrees with this recommendation. They will look into this. The Area Administrator met with the Supervisor to review actions/inactions, i.e. LEADS, all shifts alerts, daily attempts, and supervision requirements. Charges regarding work performance were pending on this Supervisor prior to this discussion. The worker of record was on medical leave. The Regional Administrator addressed all CDRT case concerns in a memo addressed to all Child Protection Supervisors in Cook County.
CS-7	Team recommends that DCFS look at this case and how it was handled due to the parents not being added to the report as alleged perpetrators.	DCFS agrees. This case was reviewed by the Area Administrator and used as a training tool in the Southern Region at an All Staff Meeting on 8/21/14.
CS-8	Team requests DCFS investigate the parents. The supervisor stated at the meeting that she did not think the parents should be added because they had already lost a child and had suffered enough and they didn't have any other children. The team is concerned because the parents knew grandmother had serious chronic mental illness and she wasn't capable of caring for the grandchild. The parents also knew the grandmother was on 14 prescribed medications and that there was not a safe place in the	DCFS does not have authority to re-open a case once it is closed. Chair requested that they use this as a training tool. DCFS agreed with that request. This case was used as a training tool in the Southern Region at an All Staff Meeting on 8/21/14.

	home for the child to sleep.	
CS-9	Team recommends that DCFS look into this case and how it was handled. DCFS closed this case on June 12, 2013 and the ME did not have the final cause of death until September 20, 2013.	DCFS agrees with this recommendation. They will look into this. This case was discussed with the supervisor on July 15, 2014. This case was also used as a training tool at an all staff meeting on August 6, 2014.
CS-10	Team requests that DCFS and OIG office look at this case in its entirety and how it was handled. - Investigation came to DCFS for allegation 74 inadequate supervision, 82 environmental neglect, and 76 inadequate food. - Investigator never talked to the doctor and did not ask for medical records. - Child had not seen doctor for 2 years and investigator never found this out. - Investigator took the parents' word that the child had borderline leukemia and that was why the child was small. This child weighed 40 pounds at death and was 10 years old. - Investigator said he knew that the child had seizure disorder but did not check to see if the child was taking seizure medication. - The investigator never talked to the school and did not know if the child was attending school or taking medication at the school. He said this was not part of the allegation. - The investigator kept saying that the house was clean and mom was working. - This child died while the investigation was still open. This investigator did not add any allegations. -The toxicology showed that this child had no Dilantin in his system and the cause of death is probable seizure. The mother admitted to refusing to give seizure medication.	DCFS agrees. DCP Administrator will meet with the Southern Region Team concerning the issues on this case.

CS-11	Team requests DCFS look at this case and how it was handled particularly in regards to the initial investigator. The initial investigator did not get any contact information and did not ask for any identification information such as driver's license which is DCFS protocol.	DCFS agrees. The Area Administrator met with the investigator and supervisor to review the requirements to secure identification upon first contact with investigation subjects. A memo was distributed to Cook County staff describing the requirement.
CS-12	Team will write a letter to the agency that was in the home prior to the death and monitoring the preemie twins concerning their safe sleeping protocol. There were no cribs in the home.	No response needed from DCFS. Team Chairperson will write the letter.
CS-13	Team requests DCFS look at this case and how it was handled. The investigator did not talk to the doctor. She called the office and the office said the child had just been seen and the doctor was out for 3 weeks. The investigator did not check to see if the child was in school. The investigator did not take into consideration that this child was a medically complex child. Team asks that DCFS use this case as a training tool.	DCFS agrees. They will look at this case and how it was handled. The Area Administrator used this investigation as a teaching tool with the investigator involved as well as during an All Staff Meeting. The Area Administrator discussed the appropriateness of indicating for medical neglect and death by neglect.
CS-14	Team recommends that DCFS look into this case and how it was handled and use this case as a teaching tool for investigations and intact. Why was this case not screened in an early sequence and why the doctor was not talked to?	DCFS agrees. They will look into this. The details of this case were reviewed by the DCFS Regional Administrator. This case was used as a training tool with the investigator and supervisor involved as well as during an All Staff Meeting with investigation and supervisory staff. During the training session emphasis was placed on adhering to all policies; assessing investigations for court intervention; making diligent efforts to contact fathers; and the importance of resolving guardianship issues.

CS-15	The team requests DCFS review this case in its entirety. There was a series of recent reports and most recently in February 2013, there was a report that was made by the school that a sibling was whipped by a belt and bruised. No attempt was made to see the bruising by DCFS and the case was unfounded. In March 2013, the school reported to the hotline that the sibling had a bump on his head due to his mother. This case was also unfounded. On September 2013, another sibling died due to being beaten by the paramour.	DCFS agrees. The Department will look into this case and how it was handled.
CS-16	Team requests DCFS look at this case and how it was handled as related to terminating safety plans, transitional visits and hand offs. In situations where the case is open to Intact while the investigation is still in progress, both workers should communicate throughout the course of the investigation. In the notes, it appeared that the DCP worker did not believe that the safety plan should have been discontinued but the intact worker and supervisor discontinued the case anyway. DCP did not block that from happening.	DCFS agrees to look at this. The Area Administrator met with the investigator and supervisor to review waivers and safety plan expectations as outlined in Procedure 300 Appendix G. The investigator and supervisor were also told to consult with the Area Administrator if an agency terminates a safety plan implemented by Division of Child Protection. The Regional Administrator also addressed all case concerns in a memo addressed to all Child Protection Supervisors in Cook County.
CS-17	Team would like this called back into the hotline so that the death can be investigated. Team requests that someone call the Coroner so this can be taken as an investigation.	A designee from DCFS spoke with the St. Clair Coroner regarding this case.
CS-18	Team requests DCFS listen to the hotline call to see if they told caller if more information was discovered, to call the hotline with the additional information. If this is not the protocol, the team requests that DCFS train hotline staff regarding this procedure.	This hotline call has been expunged from the system and as a result the call is no longer available for the Department to review.

Chapter 3: Illinois Child Deaths in 2013

What do we know about the child deaths that occurred in Illinois during 2013?

To answer this question, there are three sets of numbers that need to be compared: 1) the total population of children in Illinois, 2) the population of total child deaths in Illinois, and 3) the child deaths that were reviewed by the CDRTs.

Comparing the children who died to the total child population in Illinois can add to our understanding of how characteristics such as gender, age, and race are associated with child deaths and how children who died differ from those in the general child population in Illinois.

The third group includes child deaths reviewed by the CDRTs. The majority of reviewed deaths (98% in 2013) are mandated because the decedent's family was involved in the child welfare system in Illinois. Since the majority of reviewed cases are involved with DCFS, they might differ from the total child deaths in important ways. For example, the population of children involved with child welfare in Illinois is more likely to be younger and African-American than the total child population in Illinois. It is therefore likely that deaths reviewed by the CDRTs may over-represent these two characteristics. In order to compare 1) the total population of children, 2) the population of total child deaths, and 3) the child deaths that were reviewed by the CDRTs, these data are presented side by side throughout this report.

With this information in mind, the following provides a brief look at the three groups:

- The population of Illinois children was based on the 2010 Census. According to Census 2010 data, there were approximately 3.13 million children under the age of 18 in Illinois, which constitutes about 24.4% of the total Illinois population.

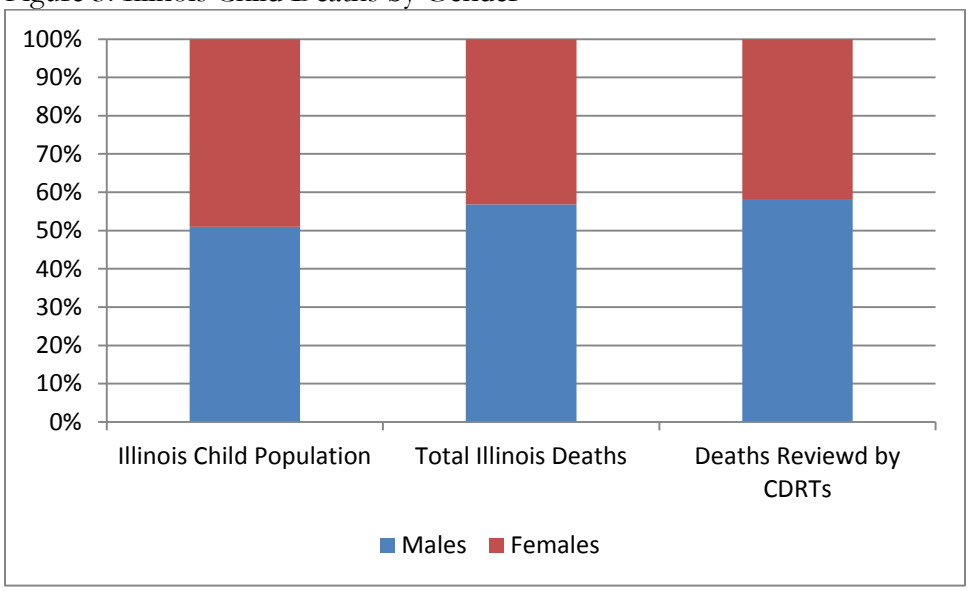
- In 2013, there were 1,503 child deaths reported to the Illinois CDRT database. This includes deaths due to all causes, preventable and non-preventable.

- There were 163 child deaths that occurred in 2013 that were reviewed by the CDRTs – 159 of these were mandated for review and 4 were discretionary reviews.

Child Deaths by Gender

According to information from the 2010 Census, 51% of the Illinois child population is male and 49% is female. However, boys are more likely to die than girls: boys made up 57% of total child deaths in 2013. More deaths reviewed were also boys: 58% of reviewed deaths were boys in 2013 (see Figure 3).

Figure 3: Illinois Child Deaths by Gender

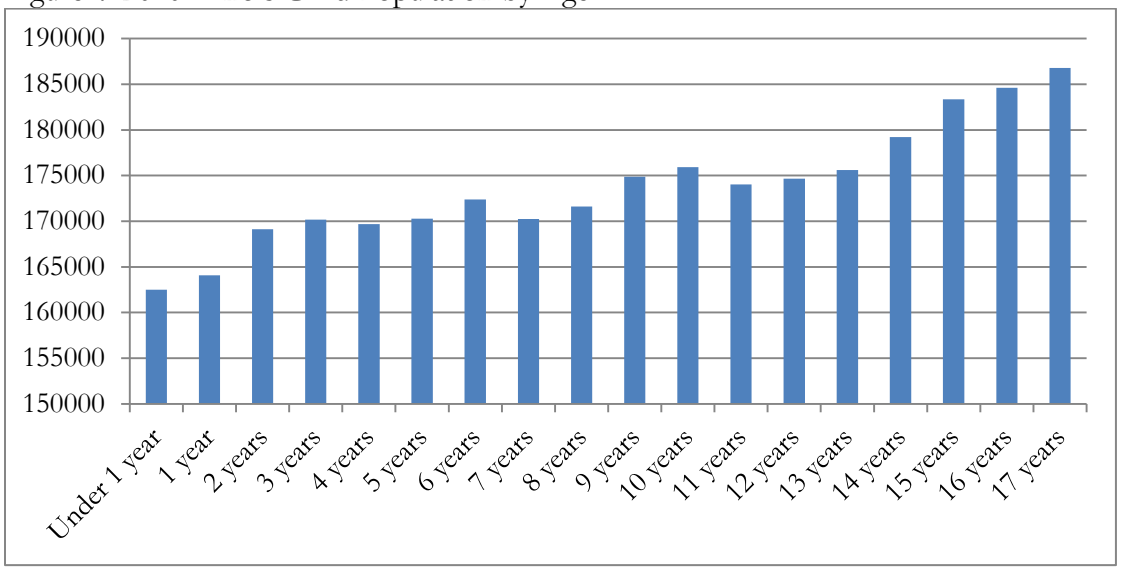


Child Deaths by Age

In 2010, there were a higher number of older children than younger children in the Illinois child population (see Figure 4). Of the 3.13 million children in Illinois under 18 years, 5% were less than one year of age, 22% were between 1 and 4 years, 27% were between 5 and 9 years, 28% were between 10 and 14 years, and 18% were between 15 and 17 years.[5]

[5] U.S. Census Bureau. (2010). *Illinois population by age*. Retrieved from http:// www. factfinder2.census.gov.

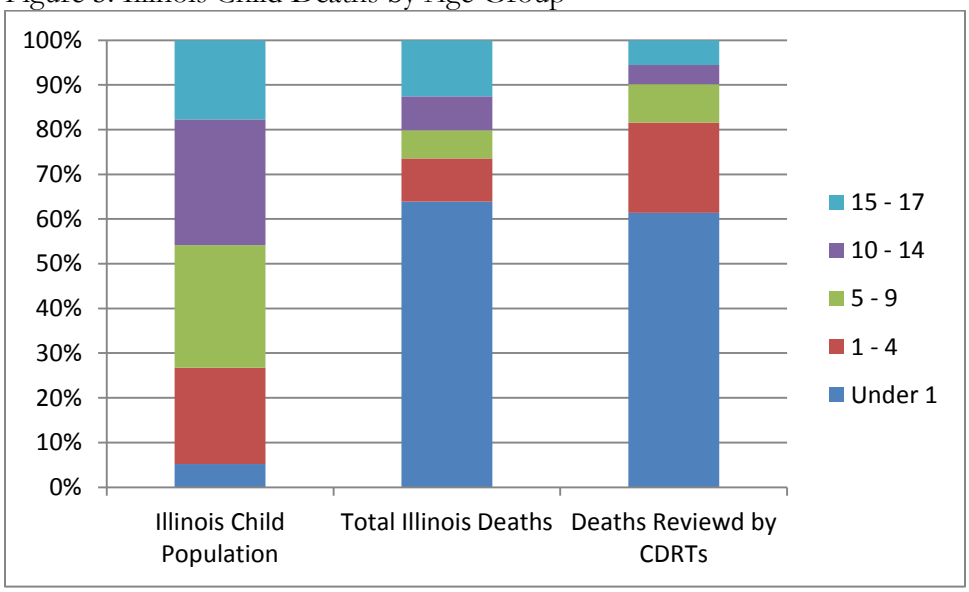
Figure 4: 2010 Illinois Child Population by Age



However, when the total Illinois child deaths reported to CDRTs are examined by age (see Figure 5), it shows that infants less than one year old are especially vulnerable – 64% of the total deaths in 2013 occurred in this age group, which is considerably higher than their proportion of the Illinois child population (5%). Older children are less likely to die: in 2013, 10% of the total deaths were children between 1 and 4 years, 6% were children between 5 and 9 years, 8% were children between 10 and 14 years, and 13% were between 15 and 17 years.

When the deaths reviewed by the CDRTs are examined by age group (see Figure 5), infants under one year are again over-represented; they comprised 61% of reviewed deaths in 2013. Children between 1 and 4 years made up 20% of reviewed deaths in 2013. Older children make up a smaller portion of reviewed deaths: 9% of reviewed deaths were for children aged 5 to 9 years old, 4% of reviewed deaths were for children aged 10 to 14, and 6% of reviewed deaths were for children aged 15 to 17.

Figure 5: Illinois Child Deaths by Age Group



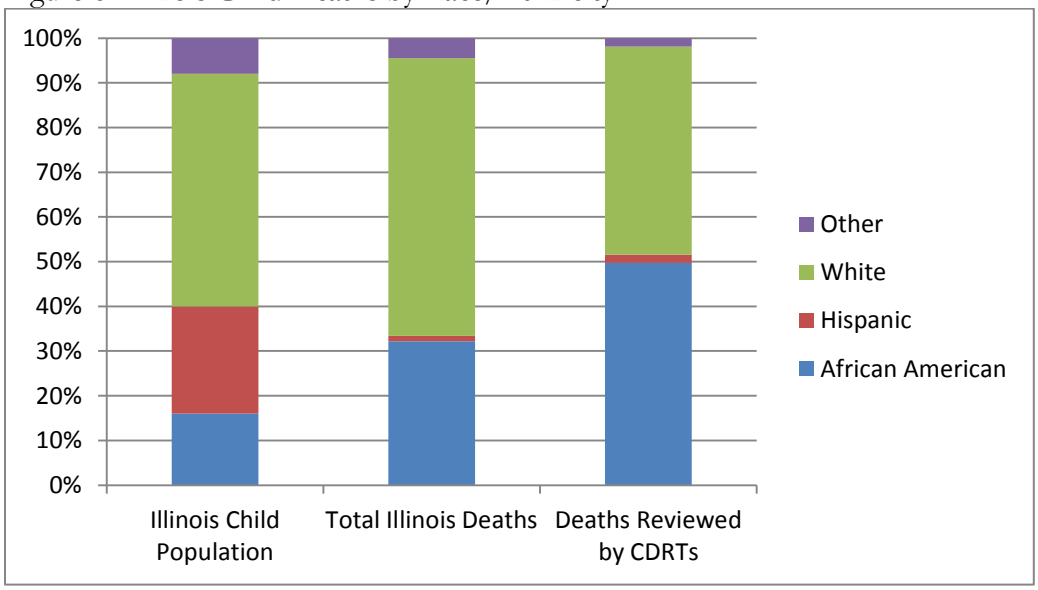
Child Deaths by Race

In 2013, there were 3 million children 17 and younger in Illinois, of whom 52% were White, 24% were Hispanic, 16% were African American, and 8% were of another race/ethnicity (see Figure 6).[6]

However, when the total Illinois child deaths are examined by race, it is evident that African-American children are at higher risk of death when compared to their numbers in the general population: 32% of the children that died in 2013 were African-American compared with roughly 16% in the general child population. The proportion of deaths among Caucasian children (62% in 2013) was also higher when compared with their proportion in the general child population (52%). Conversely, deaths among Hispanic children (1% in 2013) were infrequent compared to their numbers in the general population (24%) (Figure 6).

Among the 163 child deaths reviewed by the CDRTs in 2013, 50% were of African American children, which is larger than their proportion in the overall child population (16%) or the total child deaths that occurred in 2013 (32%) (see Figure 6).

Figure 6: Illinois Child Deaths by Race/Ethnicity



Child Deaths by Category

The CDRT Executive Council has identified 13 specific categories of death for review, in addition to categories for undetermined and "other" deaths. In this classification system, the category of death can be different from the proximal cause of death. For example, a child may have died of pneumonia (cause of death) that was the result of an earlier gunshot wound (category of death). By reviewing this death as a firearm death, the CDRT examining the case would make recommendations related to firearms rather than the illness that

[6] Annie E. Casey Foundation (2014). Kids Count Data Center. Retrieved from http://datacenter.kidscount.org/.

resulted from the gunshot. The use of categories can be helpful in the development of strategies, systems, and awareness campaigns to prevent child deaths.

Categories of death for child deaths that occurred in Illinois in 2013 are shown in Table 2. The majority of total child deaths were related to either illness (35%) or premature birth (33%). The other categories included suffocation (7%), firearms (6%), undetermined (5%), vehicular accidents (4%), injury (2%), SUID (2%), drowning (2%), fire (1%), poisoning/overdose (1%), and a few cases of SIDS, SUCD, and other types that accounted for less than 1% of the total deaths respectively. There were no deaths due to scalding burn in 2013.

Table 2: Child Deaths by Category of Death

	Total Deaths		Reviewed Deaths	
Illness	531	35%	20	12%
Prematurity	498	33%	6	4%
Suffocation	107	7%	50	31%
Firearms	85	6%	4	2%
Undetermined	69	5%	30	18%
Vehicular	67	4%	10	6%
Injury	37	2%	23	14%
SUID	32	2%	6	4%
Drowning	24	2%	10	6%
Fire	21	1%		
Poison/Overdose	17	1%	1	1%
SIDS	7	<1%	1	1%
Other	4	<1%	2	1%
SUCD	1	<1%		
Scalding burn	0		0	
Total	1500*		163	

*Note: there were 3 "pending" cases in total deaths at the time of the report.

Certain categories of child deaths are far more likely to be reviewed by CDRTs than others (see Table 2). In 2013, deaths reviewed by CDRTs were most likely to be related to suffocation (31%), undetermined (18%), injury (14%), illness (12%), vehicular (6%), drowning (6%), and SUID (4%). A detailed analysis of all the categories of deaths is included in Chapter 4 of this report.

Child Deaths by Manner

It is important to distinguish between the "category of death" and the "manner of death," a classification used by medical examiners, coroners, and physicians when completing a death certificate to clarify the circumstances of death and *how* the death arose. In most states, manner of death is classified into one of five categories:

- Natural – the death was a result of natural causes such as illness, disease, and/or the aging process

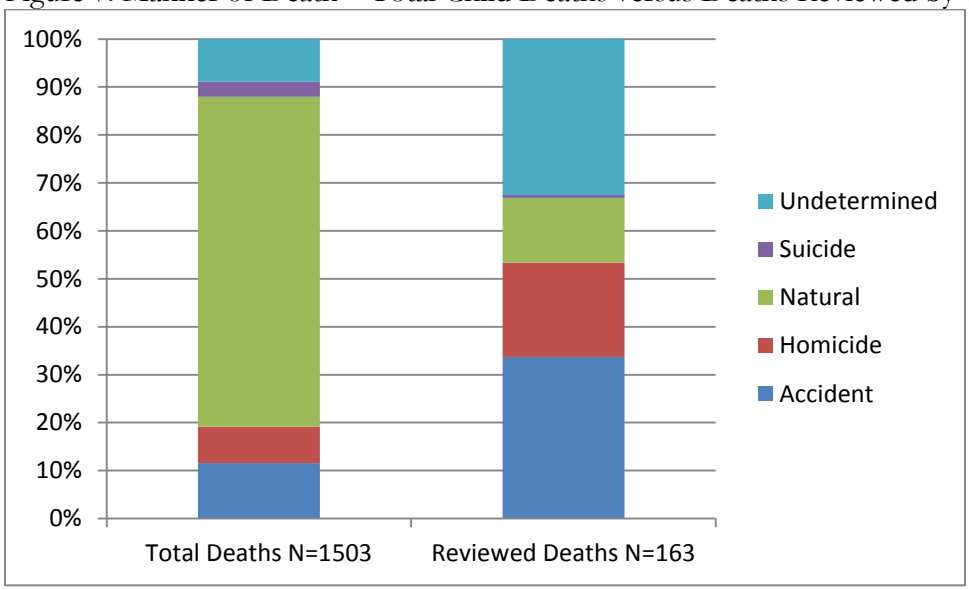
- Accident – the death was the result of a non-intentional injury
- Homicide – the death was the result of a volitional act committed by another person to cause fear, harm, or death
- Suicide – the death was the result of an intentional, self-inflicted act committed to do self-harm or death
- Undetermined – information pointing to one manner of death is no more compelling than one or more other competing manners of death when all available information is considered

The majority of total child deaths in 2013 were attributable to natural causes (69%), and accidents accounted for 12% of the total child deaths. In addition, 8% were homicides, 3% were suicides, and 9% were undetermined. When compared to total child deaths, deaths reviewed by CDRTs are much more likely to be accidents (34%), undetermined (33%), and homicides (20%); and much less likely to be due to natural causes (13%) (see Table 3 and Figure 7).

Table 3: Manner of Death – Total Child Deaths and Deaths Reviewed by CDRTs

	Total Deaths		**Reviewed Deaths**	
	N	Percent	N	Percent
Accident	174	12%	55	34%
Homicide	114	8%	32	20%
Natural	1034	69%	22	13%
Suicide	47	3%	1	1%
Undetermined	134	9%	53	33%
Total	1503		163	

Figure 7: Manner of Death – Total Child Deaths versus Deaths Reviewed by CDRTs



Child Deaths by Category and Manner

It is interesting to examine the manner of child death juxtaposed with the categories of death (see Table 4). For instance, the majority of accidental child deaths are due to vehicular accidents and suffocations followed by drowning, and fire related causes. Most homicides involve either firearms or other inflicted injuries. Hanging (suffocation) is the most frequent method of child/youth suicide, followed by firearms. Almost all child deaths due to natural causes are the result of premature birth and illness.

Table 4: Total Child Deaths – Manner of Death by Category of Death

Category of Death	**Manner of Death**					
	Accident	Homicide	Natural	Suicide	Undetermined	Totals
Illness	1		522		8	531
Prematurity	1	1	494		2	498
Suffocation	58	3	4	27	15	107
Firearms	3	65		15	2	85
Undetermined					69	69
Vehicular	60	5		1	1	67
Injury	5	31		1		37
SUID			7		25	32
Drowning	21	2			1	24
Fire	12	5			4	21
Poison/Overdose	12	1		3	1	17
SIDS			5		2	7
Other	1[1]	1[2]	1[3]		1[4]	4
Pending					3	3
SUCD			1			1
Scalding burn						0
Total	174	114	1034	47	134	1503

Note: [1]Hypothermia - exposure to cold; [2]Heat stroke; [3]Fetal anomalies; [4] Hyperthermia

Child Deaths by Review Type

There are multiple reasons that the death of a child would be reviewed, including 5 different types for which the review is mandated as well as some cases that were discretionary.

DCFS Ward: The deceased child was a ward of DCFS at the time of death. Two deaths that were mandated for review because they were DCFS wards at the time of death.

- One decedent was a male and another was a female.
- One decedent was 1 to 4 years old, and another was 5 to 9 years old.
- One death was due to drowning, and another was due to vehicular incidents.
- Both deaths were due to accidents.

Death Indicated: The allegation of death is indicated for the child's guardian. This was the largest mandatory review type, comprising 109 of the 163 cases that were reviewed. In the

death indicated review type:

- Slightly over half (64%) of decedents in this type of review were males.
- The majority was very young: 68% were infants, 20% were 1 to 4 years old, 7% were 5 to 9 years old, and the remaining 5% were 10 years and older.
- The majority of deaths were the result of three categories: suffocation (38%), injury (20%), and undetermined reasons (18%). All other categories of death compromised a total of 24%.
- The largest manner of deaths was accidental (38%), followed by undetermined (34%), homicides (25%), and natural causes (4%).

Indicated Report at Time of Death: DCFS has a founded allegation on the guardian of the child. There were 21 deaths that were mandated for review because there was an indicated report at the time of death.

- The majority of decedents in this type of review were male (71%).
- Most deaths in this type (81%) were infants, 14% were 1 to 4 years old, and 5% were 10 to 14 years and older.
- Most of these deaths occurred from suffocation (24%), illness (14%), or were due to undetermined causes (48%).
- The manner of death included 57% undetermined, 19% accidental, 19% natural causes, and 5% homicides.

Investigation within Year of Death: DCFS had done an investigation in the year before the child's death. This is the second largest type of mandated review, and 26 children who died in 2013 had been investigated in the year before their death.

- The majority (54%) of the deaths in this type were males.
- 42% of the deaths in this type were 4 years old and younger, 34% were 5 to 14, and the remaining 23% were 15 to 17 years old.
- The largest proportions of the deaths in this type were due to illness (46%), drowning (12%), firearms (12%), and suffocation (12%). Other categories were all below 10%.
- Nearly half (46%) of the deaths in this type were due to natural causes, 23% were accidental, 15% were undetermined, 12% were homicides, and 4% were suicides.

Open Case: There was an open case at the time of death. The child may be a ward of the state or the family may have an open case. There was 1 child death in 2013 of children who had an open DCFS case.

- The child was a female.
- The child was an infant.
- The death was the result of illness.
- The death was due to natural causes.

Discretionary: These deaths were not mandated for review. There were 4 deaths that were reviewed but not mandated.

- The majority (75%) of the deaths in this type were males.
- Two deaths were infants (50%), and another two deaths (50%) were children of 1 to 4 years old.
- Deaths that were discretionarily reviewed occurred from vehicular accidents (50%),

suffocation (25%), and infant death from unknown causes (25%).

- Three deaths in this type were accidental deaths, and one death was due to natural causes.

Special Analysis: Homicide Deaths

There were 114 homicide deaths out of the 1,503 deaths in 2013. We know from the above tables that the majority of homicides involved either firearms or inflicted injuries of some kind. In addition, we know that 55% of homicides were youth age 15 to 17 and that 80% of the victims were male. Additional information on homicide deaths allows for a more complete understanding of the circumstances of these types of child deaths. The deaths are presented by frequency of homicide category.

Table 5: Homicide Deaths

Category	Age	Circumstance	Perpetrator
Drowning	Infant	Baby delivered into and drown in toilet.	Mother
	Infant	Baby delivery into and drown in toilet	Mother
Fire	5	Structural fire, arson	Unknown
	5	Arson	Unknown
	8	Building fire, arson	Unknown
	9	Structural fire, arson	Unknown
	12	Structural fire, arson	Unknown
Firearms	Infant	Gunshot wound to shoulder	Unknown
	1	Gunshot wound to chest & abdomen	Unknown
	4	Gunshot wound to face	Unknown
	5	Gunshot wound to head	Unknown
	5	Multiple gunshot wounds	Father
	13	Gunshot wound to abdomen	Unknown
	14	Multiple gunshot wounds	Unknown
	14	Multiple gunshot wounds	Unknown
	14	Multiple gunshot wounds	Unknown
	14	Gunshot wound to head	Unknown
	14	Gunshot wound to arm	Unknown
	14	Multiple gunshot wounds	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to back	Unknown
	15	Gunshot wound to back	Unknown
	15	Gunshot wound to back	Unknown
	15	Gunshot wound to head	Unknown
	15	Gunshot wound to head	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to back	Unknown
	15	Gunshot wound to arm	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Multiple gunshot wounds	Unknown
	15	Gunshot wound to chest	Unknown

	15	Gunshot wound	Unknown
	15	Gunshot wound to back	Unknown
	16	Gunshot wound to chest	Unknown
	16	Gunshot wound to neck	Unknown
	16	Gunshot wound to back	Unknown
	16	Gunshot wound to face	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Gunshot wound to head	Relative
	16	Multiple gunshot wounds	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Gunshot wound to back	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Multiple gunshot wounds	Unknown
	16	Gunshot wound to head	Unknown
	17	Gunshot wounds to head and neck	Unknown
	17	Gunshot wound to head	Unknown
	17	Gunshot wound to head	Unknown
	17	Gunshot wound to head	Unknown
	17	Gunshot wound to head	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Gunshot wound to the head	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Gunshot wound to head	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Gunshot wound to head	Unknown
	17	Gunshot wound to head	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Gunshot wound to chest	Unknown
	17	Gunshot wound to back	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Gunshot wound to flank	Unknown
	17	Gunshot wounds to head and abdomen	Unknown
	17	Gunshot wound to head	Unknown
	17	Multiple gunshot wounds	Unknown
	17	Multiple gunshot wounds	Unknown
Injury	Infant	Abusive closed head injury	Mother & father
	Infant	Abusive head trauma	Father
	Infant	Multiple stab and incised wounds	Mother

	Infant	Abusive closed head injury	Father
	Infant	Multiple traumatic head injuries; child abuse	Mother & her paramour
	Infant	Multiple inflicted traumas; child abuse	Father
	Infant	Multiple injuries; child abuse	Relative
	Infant	Blunt force injuries of head and incised wounds of neck; child abuse	Grandmother
	Infant	Multiple blunt force injuries; child abuse	Paramour
	Infant	Complications of a hypopharyngeal injury; child abuse	Father
	Infant	Multiple injuries; child abuse	Unknown
	Infant	Blunt force injuries; child abuse	Father
	Infant	Abusive closed head injury	Unknown
	1	Multiple blunt force injuries; child abuse	Mother & her paramour
	1	Head trauma; child abuse	Paramour
	2	Multiple beating injuries; child abuse	Relative
	2	Blunt force trauma to the head; child abuse	Paramour
	2	Multiple injuries due to dog attack; neglect	Grandfather's dog
	3	Multiple blunt trauma; child abuse	Paramour
	3	Blunt force trauma; child abuse	Paramour
	5	Blunt force injury to the chest; child abuse	Paramour
	7	Cutting and stab wounds to shoulder and neck; child abuse	Relative
	8	Multiple blunt force injuries; child abuse	Grandmother
	8	Sharp force injuries to neck and chest; child abuse	Mother
	14	Multiple stab wounds	Unknown
	14	Multiple stab wounds	Mother & babysitter
	16	Shaken infant syndrome	Babysitter
	17	Acute cardiac tamponade hemopericardium; perforation of the heart	Unknown
	17	Sharp force injuries to neck and chest	Unknown
	17	Multiple stab and incised wounds	Unknown
	17	Complications of blunt force injuries	Unknown
Other	1	Heat stroke; child neglect	Father
Poison/ overdose	17	Drug overdose	Unknown
Prematurity	Infant	Extreme prematurity; acute chorioamnionitis; premature rupture of membranes	Mother
Suffocation	Infant	Asphyxia suffocation	Father & mother
	Infant	Mechanical asphyxiation	Unknown

	Infant	Suffocation	Paramour
Vehicular	11	multiple injuries due to motor vehicle accident	Unknown
	16	Multiple traumatic injuries due to vehicle accident	Unknown
	16	Craniocerebral injuries due to vehicle accident	Unknown
	17	Atlanto-occipital disarticulation due to vehicle accident	Driver
	17	Multiple traumatic injuries due to vehicle accident	Unknown driver

Chapter 4: Child Deaths by Category

To gain a more complete understanding of child deaths in Illinois, the following sections present detailed analyses for the categories of death identified by the CDRT Executive Council. By examining the characteristics of the children who die from a specific cause of death, more explicit and useful recommendations for preventing future child deaths can be made.

Categories are presented in the order of frequency of occurrence for 2013 so that the most common categories of death are first. For each category section, the following information is presented:

- Category definition describes the types of deaths that are included.
- Background information provides national statistics or research findings, if available.
- Illinois data on total child deaths reported to the CDRTs.
- Numbers of deaths from categories over the past 10 years are presented and trends are noted when applicable.
- Illinois data on child deaths that are reviewed by the CDRTs.
- Charts compare the gender and age of three groups: 1) the total child deaths, 2) deaths from a specific category, and 3) reviewed deaths from that category.

There is an important fact to remember about these analyses. The deaths reviewed by the CDRTs are not a representative sample of all child deaths in Illinois. It is mandatory that any death of a child involved with DCFS in the past 12 months must be reviewed. Since the child welfare system in Illinois over-represents African-American children and young children, the cases reviewed by the CDRT are more likely to be younger or African-American.

Illness

Definition

This category includes any death that was the result of a medical condition. The manner of death for this category is most often determined to be natural. On occasion, however, the manner of death may be determined to be accidental. An accidental determination would include children whose death was caused by an accident related to their illness, such as malfunctioning medical equipment or surgical error (for example, accidental removal of tracheotomy tubes).

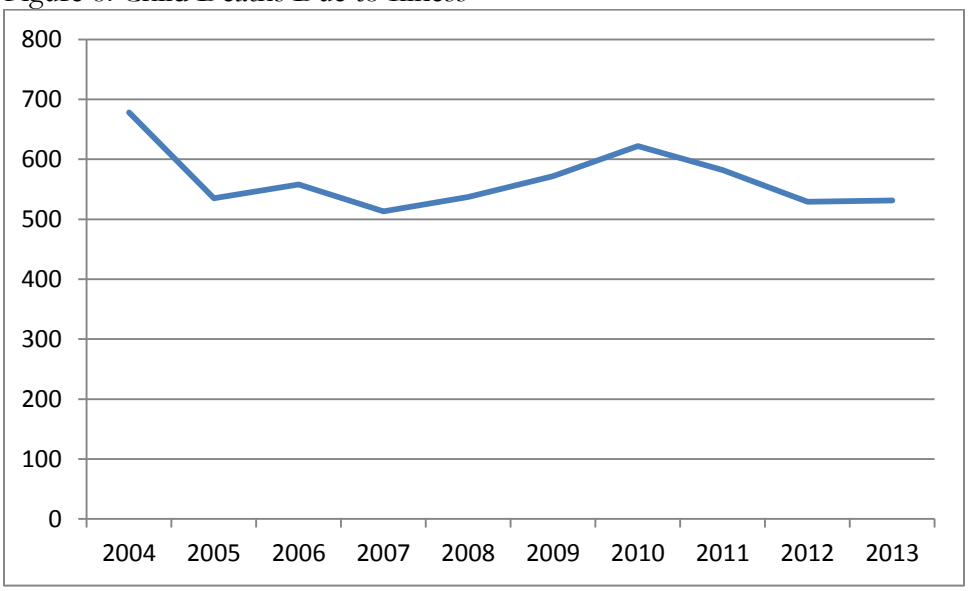
Background

A death due to illness can result from one of many serious health conditions, such as congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart or respiratory disorders, and infections. Although many of these conditions are not believed to be preventable in the same way that accidents, homicides, and suicides are preventable, deaths from certain illnesses, such as neural tube defects, asthma, infectious diseases, and some screenable genetic disorders are now believed to have a preventable component.

Illinois Data – Total Child Deaths Reported to the CDRTs

For the past decade, illness has been one of the largest causes of child death. The number of deaths from illness has ranged from 513 in 2007 to 678 in 2004 (see Figure 8).

Figure 8: Child Deaths Due to Illness



In 2013, 531 of the 1,503 total child deaths (35%) reported to CDRTs were related to illness.

- The vast majority of these deaths (98%) were attributable to natural causes, and the others were undetermined.
- A slight majority of children who died from illness were male (53%).

- A little more than half of deaths from illness were among children under the age of one (53%); 16% of deaths from illness occurred among children 1 to 4 years old, 11% occurred among children 5 to 9 years old and 10 to 14 years old respectively, and 9% occurred among children 15 to 17 years old.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 20 of the 163 child deaths reviewed by the CDRTs (12%) were related to illness.

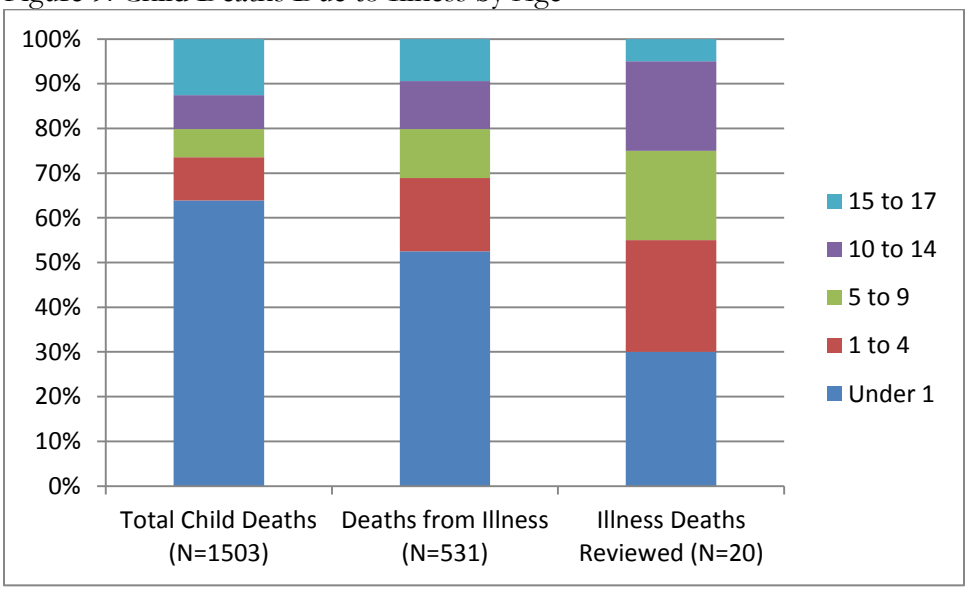
- Half of the reviewed deaths related to illness were boys.

- Infants (30%) and children aged 1 to 4 years (25%) represent the largest percentage of deaths from illness reviewed by CDRTs. Reviewed deaths from illness also included 20% of children 5 to 9 years old and 10 to14 years old respectively, and 5% of children 15 to 17 years old.

- Most (85%) deaths that were categorized as illness were natural, and the remaining 15% deaths were undetermined.

The age distributions of the total child deaths, deaths resulting from illness, and deaths resulting from illness that were reviewed by the CDRTs in 2013 are presented in Figure 9. When comparing total child deaths and child deaths due to illness across age groups, infants less than 1 year old were the largest proportions in the total child deaths, child deaths from illness, and reviewed child deaths from illness. Children under 5 accounted for the majority of child deaths, and that is also the case for child deaths from illness. Except for a smaller proportion for the age group of 15 to 17 years old, child deaths in other age groups accounted for a similar proportion (20% to 30%) of the reviewed deaths due to illness.

Figure 9: Child Deaths Due to Illness by Age



Premature Birth

Definition

Although there is no single, agreed-upon measure that is used to define premature (or preterm) birth, a birth is *generally* determined premature if it occurs before the 37th week of gestation. Preterm births are sometimes classified as "very preterm" (less than 32 weeks gestation) and moderately preterm (32 – 37 weeks gestation). In Illinois, deaths in this category include aborted pregnancies where a death certificate was completed, but not fetal deaths. The manner of death associated with prematurity is most often determined to be natural. However, if an infant is born prematurely due to maternal injury, the manner of death may be ruled accidental or homicide.

Background

Premature birth is closely associated with low birth weight. According to the U.S. Department of Health and Human Services, period of gestation and birth weight are the two most important predictors of neonatal mortality. Preterm birth is often associated with low birth weight. Low birth weight babies (less than 2,500 grams) and very low birth weight babies (less than 1,500 grams) are more likely to die during the first four weeks of life than babies weighing more than 2,500 grams. Infants born at the lowest birth weights and gestational ages have a large impact on infant mortality.[7] Following many years of increases, the national preterm birth rate declined continuously, from 12.8% in 2006 to 11.5% in 2012.[8]

In Illinois, about 1 in 8 babies (12.0% of live births) was born preterm in 2012.[9] Between 2002 and 2012, the rate of infants born preterm in Illinois declined nearly 5%. The rate of preterm birth in Illinois is highest for African American infants (17.0%), followed by Native Americans (13.0%), Hispanic (12.1%), whites (10.7%), and Asians (10.6%).[10] A number of risk factors have been associated with preterm birth: maternal age, history of preterm birth, multi-fetal pregnancy, stress, infection, cigarette smoking and other substance use during pregnancy, obesity, and elevated blood pressure.[11] Early access to quality prenatal care can increase the likelihood that babies are born at normal birth weights.

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[7] America's Health Rankings (2014). A call to action for individuals and their communities. United Health Foundation (2013 Edition). Retrieved from http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/AnnualReport2013-r.pdf

[8] Federal Interagency Forum on Child and Family Statistics (2014). *At a glance for 2014 America's children: key national indicators of well-being.* Retrieved from http://www.childstats.gov/pdf/ac2014/ac_14.pdf.

[9] National Center for Health Statistics. *Illinois prematurity data.* Retrieved from http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4.

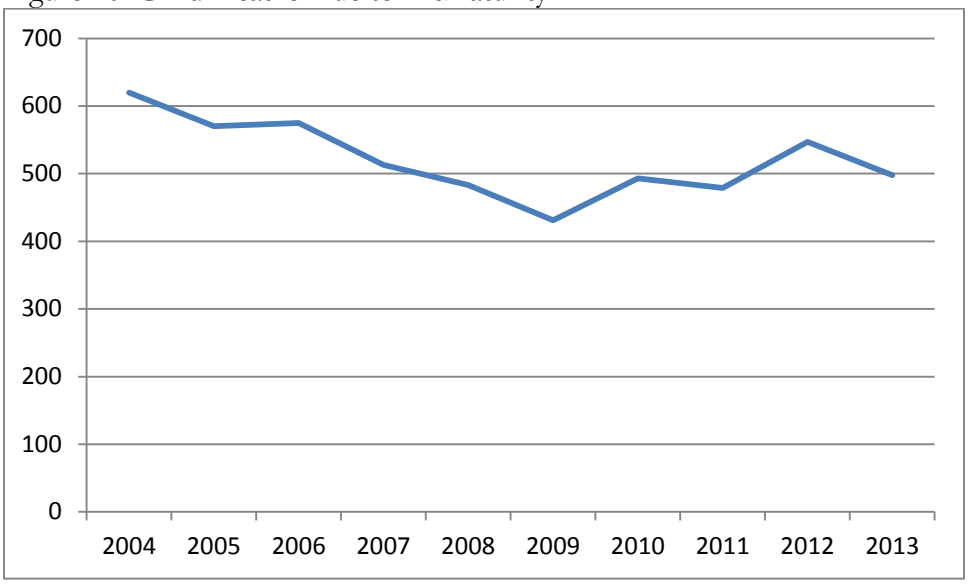
[10] National Center for Health Statistics. *Illinois prematurity data*. Retrieved from http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=17&top=3&lev=0&slev=4.

[11] Howse, J., & Cladwell, M. (2004). The state of infant health: Is there trouble ahead? *America's health: State rankings, 2004 Edition*. United Health Foundation.

Illinois Data – Total Child Deaths Reported to the CDRTs

Prematurity has been a leading cause of child death and has either been the second largest or the largest category in the past 10 years (ranging from 431 to 620 deaths per year). There was a decreasing trend in deaths due to prematurity during 2004-2009, but the trend reversed after 2009 and the numbers increased until 2012. A decrease in 2013 may signal the beginning of another decline in premature births, although this will not be known until additional monitoring occurs (see Figure 10).

Figure 10: Child Deaths Due to Prematurity



Of the 1,503 total child deaths in 2013, 498 (33%) were related to premature birth.

- Over 99% of the deaths in this category (494) were the result of natural causes, 1 was an accident, 1 was a homicide, and 2 were undetermined.
- A slight majority of children who died from prematurity were boys (53%).

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 6 of the 163 child deaths reviewed by CDRTs (4%) were related to premature birth.

- 4 of the premature deaths reviewed by the CDRTs were the result of natural causes, 1 was a homicide, and 1 was undetermined.
- Most (83%) of the premature deaths reviewed by the CDRTs were males.

Suffocation

Definition

Child deaths due to suffocation result from obstruction of the airway from a variety of causes. Deaths due to suffocation can be accidents, suicides, or homicides. Most unintentional or accidental suffocations are caused by:

- Choking – food or another small object blocks the internal airway.
- Positional asphyxia – a child's external airway (i.e., nose and mouth) is blocked by objects or materials such as soft bedding, pillows, bumper pads, etc., or the child becomes wedged in a small space such as between a mattress and a wall or between couch cushions.
- Overlaying – a person sleeping with a child rolls onto the child and unintentionally suffocates the child.
- Confinement – a child is trapped in an airtight place such as an unused refrigerator.
- Strangulation – a rope, cord, or other object becomes wrapped around a child's neck and restricts breathing.

When examining the information on child deaths due to suffocation, it is important to note that many medical examiners or coroners will not list an infant death as suffocation due to overlaying or positional asphyxia unless there is unequivocal evidence, such as an eyewitness account. If there is no such evidence, these types of suffocation deaths may be listed as unknown infant deaths, SIDS, or undetermined deaths. Thus, the actual number of deaths due to suffocation may be under-reported.

Background

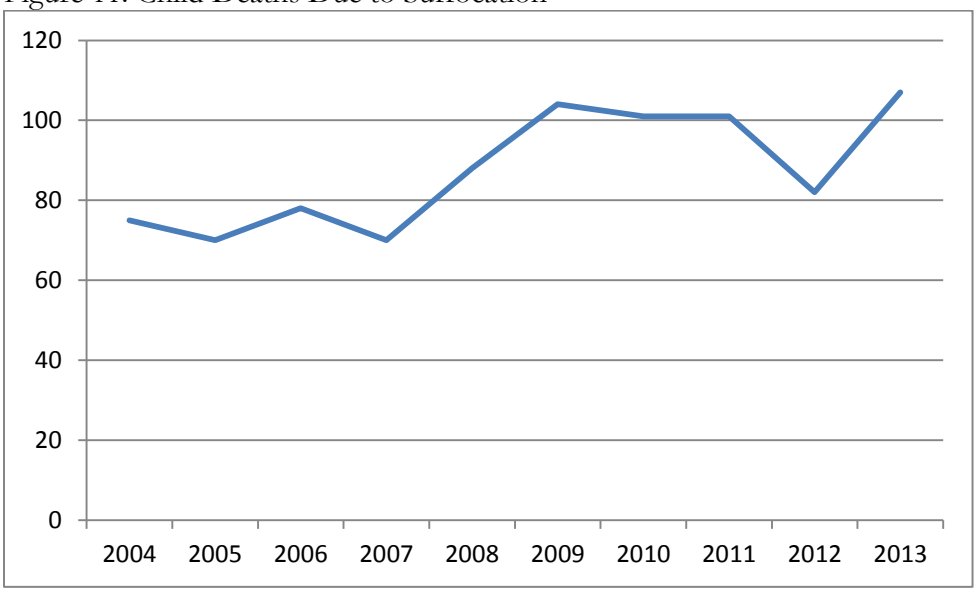
In 2012, 1,968 children ages 17 and under in the U.S. died from suffocation.[12] Of these children, 52% were less than one year of age and 61% were ages four and under. Accidental suffocation is the leading cause of injury-related death among infants less than one year old, and 70% of suffocation deaths among infants are from accidental suffocation or strangulation in bed.[13]

[12] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.
[13] Safe Kids Worldwide. (2014). *Suffocation Prevention and Sleep Safety*. Retrieved from http://www.safekids.org/suffocation-prevention-and-sleep-safety

Illinois Data – Total Child Deaths Reported to the CDRTs

There has been generally a rise in deaths from suffocation in the past 10 years, and the number in 2013 is the peak in the past 10 years (see Figure 11).

Figure 11: Child Deaths Due to Suffocation



In 2013, 107 of the 1,503 total child deaths reported to the CDRTs (7%) were related to suffocation.

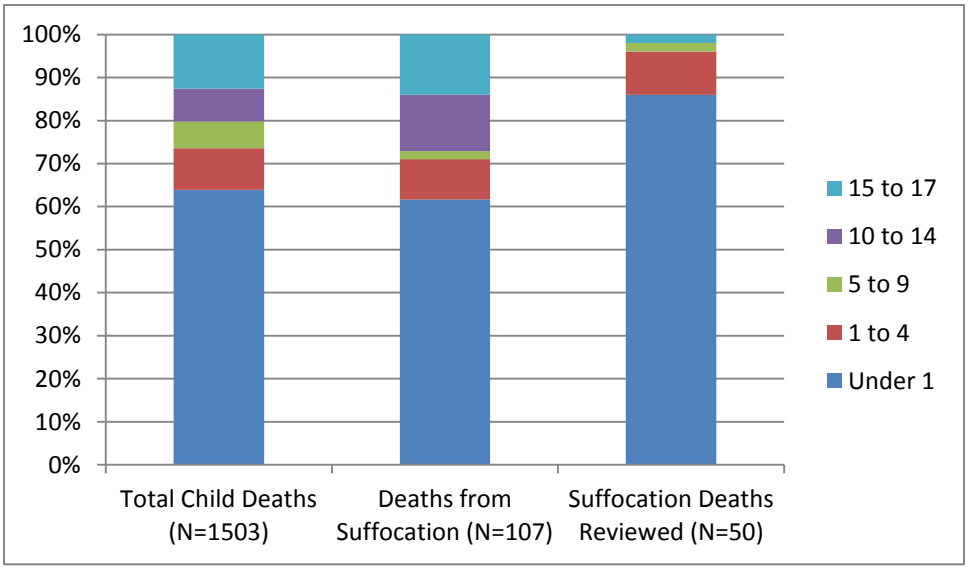
- The manner of the suffocation deaths varied: 54% were accidental, 25% were suicides, 14% were undetermined, 4% were natural, and 3% were homicides.
- The majority of children who died from suffocation were boys (57%).
- Infants under one year were the largest group in this category, accounting for 62% of the deaths.

Illinois Data – Deaths Reviewed by CDRTs

In 2013, 50 of the 163 deaths reviewed by CDRTs (31%) were related to suffocation.

- Slightly more than half (56%) of the reviewed suffocation deaths were male.
- Infants under one year accounted for the majority of the reviewed suffocation deaths (86%). Infant deaths were over represented in the reviewed child deaths due to suffocation, when compared to the proportion of total infant deaths due to suffocation in 2013 (see Figure 12).

Figure 12: Child Deaths Due to Suffocation by Age



Firearm

Definition

This category includes all deaths that are the result of gunshot wounds. The manner of death within this category may be determined to be homicide, suicide, or accident.

Background

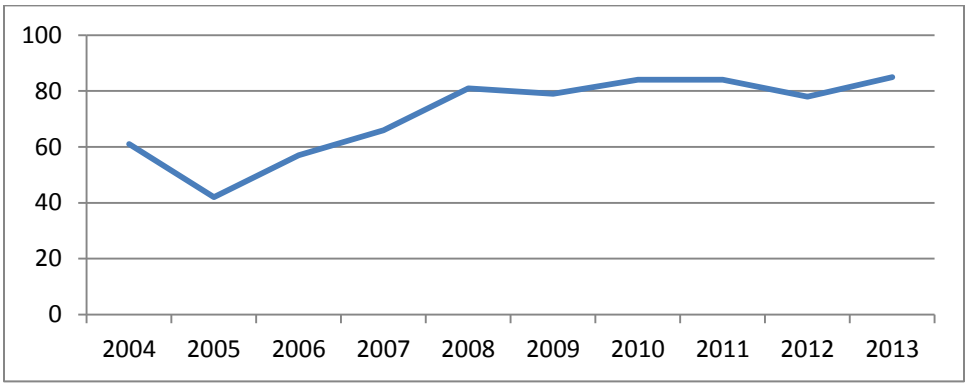
According to data from the Center for Disease Prevention and Control, 1,301 firearm deaths occurred in 2012 among children under 18 years of age in the United States.[14] The vast majority (68%) of these deaths were youth between the ages of 15 and 17. However, race of decedent is also a factor. In 2012, the homicide rate for African American male teens was more than 20 times higher than the rate for white male teens.[15]

Firearms include several manners of deaths. Suicides and homicides are the second and third leading causes of death, respectively, among teens age 15 to 19 (after unintentional injury). Firearms were the instrument of death in 88% of teen homicides and 42% of teen suicides in 2012. In two-thirds of the homicides, the murderer was over 18.[16] A recent national study from the Journal of Pediatrics found that the most-rural counties have virtually identical pediatric firearm mortality compared with the most-urban counties. The most-rural counties had higher rates of pediatric firearm suicide and unintentional firearm death but lower homicide rates when compared with the most-urban counties.[17]

Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from firearms steadily increased from 2005 to 2008 and have remained fairly level each year since then (between 79-85, see Figure 13).

Figure 13: Child Deaths Due to Firearms



[14] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

[15] Child Trends. (2014). *Teen homicide, suicide, and firearm deaths*. Retrieved from http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths

[16] Ibid.

[17] Nance, M. L., Carr, B. G., Kallan, M. J., Branas, C. C., & Wiebe, D. J. (2010). Variation in pediatric and adolescent firearm mortality rates in rural and urban US counties. *Pediatrics,* 125, 1112 -1118.

In 2013, 85 of the 1,503 total deaths (6%) were related to firearms.

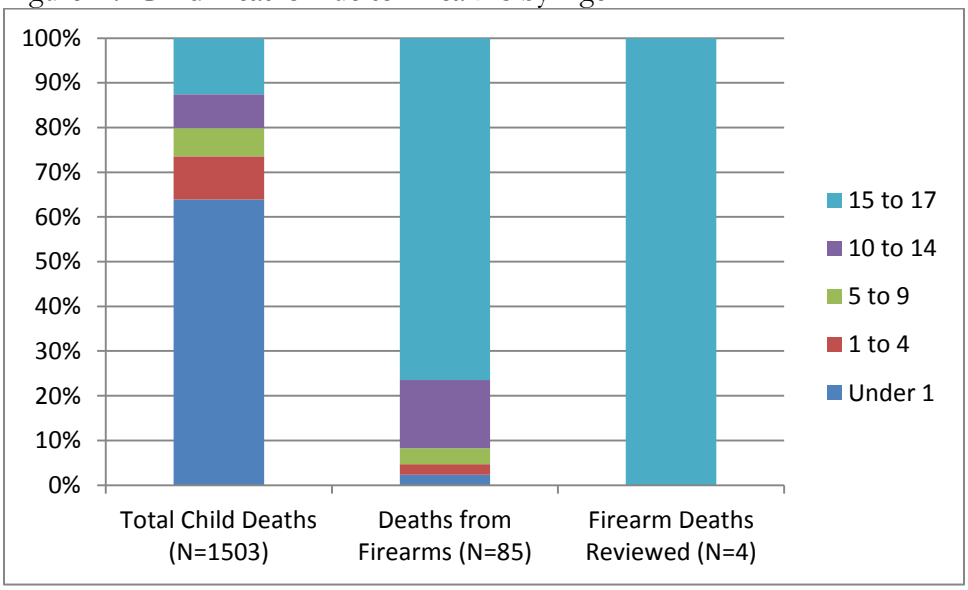
- Homicides accounted for 76% of the firearm deaths, suicides accounted for 18%, and accidents and undetermined causes accounted for the remaining 6%.
- Deaths due to firearms overwhelmingly occurred among boys (87%).
- Children between 15 and 17 years of age were largely over-represented in firearm deaths when compared to total child deaths. In 2013, 76% of firearm deaths occurred in children aged 15 to 17(see Figure 14).

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 4 of the 163 deaths reviewed by the CDRTs (2%) were related to firearms.

- The firearm deaths reviewed by CDRTs were all due to homicides.
- The firearm deaths reviewed by CDRTs were all 15 to 17 years old (see Figure 14).

Figure 14: Child Deaths Due to Firearms by Age



Undetermined Deaths

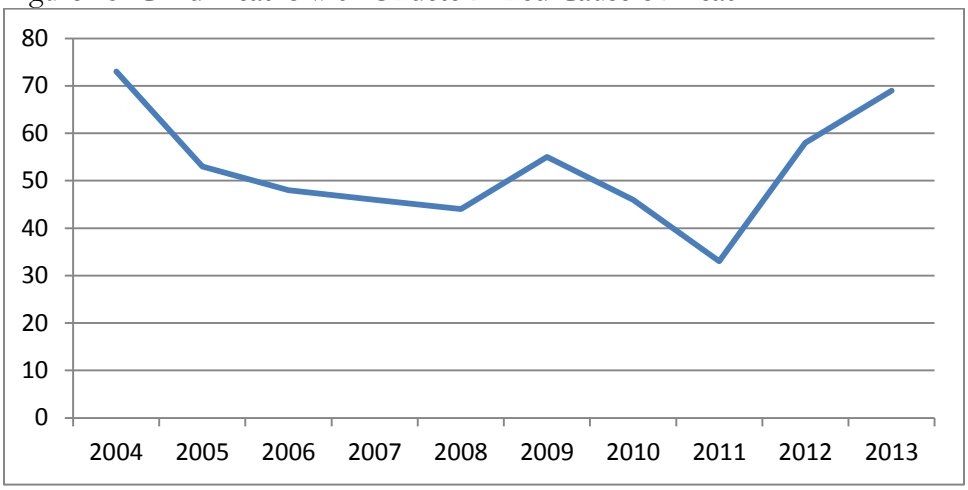
Definition

This category includes those deaths in which there was not enough evidence for the coroner or medical examiner to definitively determine the cause of death on the death certificate.

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of undetermined deaths for children dropped from 73 in 2004 to 33 in 2011, but there has been a significant increase in the number of undetermined deaths since 2011 (see Figure 15).

Figure 15: Child Deaths with Undetermined Cause of Death



In 2013, 69 of the 1,503 total child deaths reported to the CDRTs (5%) had an undetermined cause of death.

- Deaths due to undetermined causes were slightly more common for girls (56%).
- Nearly all deaths due to undetermined causes were children under the age of 1 (88%) and 1 to 4 years old (10%), with only one death older than 4 years old.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 30 of the 163 deaths reviewed by CDRTs (18%) had an undetermined cause of death.

- The majority of reviewed deaths due to undetermined causes were girls (63%).
- Nearly all reviewed deaths due to undetermined causes were children under the age of 1 (87%) and 1 to 4 years old (10%), with only one death older than 4 years old.

Vehicular Accident

Definition

Included in this category are all deaths occurring to children who are drivers, passengers, pedestrians, or occupants of other forms of vehicles such as bicycles, snowmobiles, motorcycles, ATVs, sleds, trains, etc. The manner of death is usually accidental, but can include deaths ruled to be suicides or homicides as well.

Background

Nationally, a total of 952 children (under the age of 13) died in motor vehicle crashes in 2012.[18] The rate of motor vehicle crash deaths per million children under 13 has decreased 77% since 1975. In 2012, 67% of child motor vehicle crash deaths were passenger vehicle occupants, 22% were pedestrians, and 4% were bicyclists. Since 1975, child pedestrian and bicyclist deaths each declined by 89% and 92%, respectively. Passenger vehicle child occupant deaths in 2012 were 46% lower than in 1975. It is recommended that children 12 and younger ride in the rear seats of vehicles. Fourteen percent of the passenger vehicle child occupant deaths in 2012 occurred in front seats, down from 46% in 1975. Seventy-eight percent were in the rear, and the rest occurred in cargo or unknown areas. Child deaths in motor vehicle crashes have declined since 1975, but crashes still cause about 1 of every 4 unintentional injury deaths among children younger than 13. Most crash deaths occur among children traveling as passenger vehicle occupants, and proper restraint use can reduce these fatalities. Placing children 12 and younger in rear seats instead of front seats reduces fatal injury risk by about a third.[19]

A total of 2,823 teenagers ages 13 to 19 died in motor vehicle crashes in 2012. This is 68% fewer than in 1975 and 7% fewer than in 2011. About 2 out of every 3 teenagers killed in crashes in 2012 were males. In 2012, teenagers accounted for 8% of motor vehicle crash deaths. They comprised 10% of passenger vehicle (cars, pickups, SUVs, and vans) occupant deaths among all ages, 6% of pedestrian deaths, 3% of motorcyclist deaths, 11% of bicyclist deaths, and 13% of all-terrain vehicle rider deaths.[20]

In the United States, teenagers drive less than most adults (only drivers who are over the age of 70 drive less), but their numbers of crashes and crash deaths are disproportionately high. In the United States, the fatal crash rate per mile driven for 16 to 19 year-olds is nearly 3 times the rate for drivers ages 20 and over. Risk is highest at ages 16 to 17. In fact, the fatal crash rate per mile driven is nearly twice as high for 16 to 17 year-olds as it is for 18 to 19 year-olds. Crash rates for teenagers are high largely because of their immaturity combined with driving inexperience.[21]

Distracted driving is often the cause of fatal accidents. For teen drivers, the most common distraction is using a cell phone. Other common sources of distraction for teen drivers are

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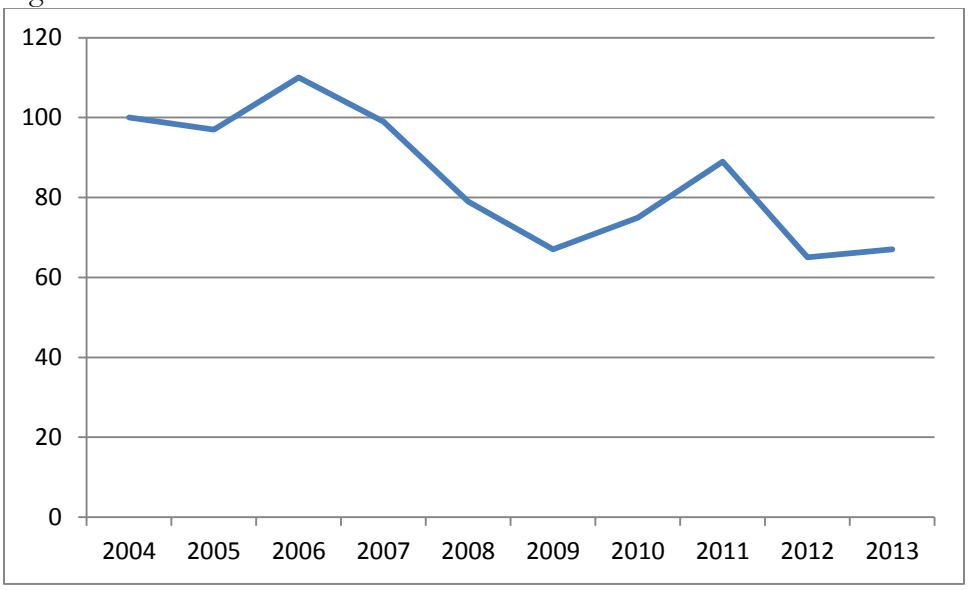
[18] Insurance Institute for Highway Safety. (2014). *Fatality facts 2012: Children.* Retrieved from http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety.
[19] Ibid.
[20] Insurance Institute for Highway Safety. (2014). *Fatality facts 2012: Teenagers.* Retrieved from http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers.
[21] Ibid.

riding with peers and drowsiness.[22] Another factor that affects teenage vehicular fatalities is inexperience. In order to address this, all states have adopted graduated licensing systems, which phase in full driving privileges. In states that adopted elements of graduated licensing, the crash rates among teenage drivers declined about 10-30%.[23]

Illinois Data – Total Child Deaths Reported to the CDRTs

After dropping from a high of 110 vehicular deaths in 2006 to a low of 65 in 2012, the number of deaths due to vehicular accidents in 2013 remained similar to that of 2012 (see Figure 16).

Figure 16: Child Deaths Due to Vehicular Accidents



In 2013, 67 of the 1,503 total child deaths reported to the CDRTs (4%) were related to vehicular accidents.

- A large majority (90%) of these deaths were accidental, and small portions were homicides (7%), suicides (1%), and undetermined (1%).
- More boys (66%) had deaths related to vehicular accidents.
- Older children (15 to 17) made up the largest proportion of vehicular accident deaths (40%). Children in other age groups included 19% of 1 to 4 years old, 21% of 5 to 9 years old, and 19% of 10 to 14 years old, but no child under 1 was related to vehicular accidents (see Figure 17).

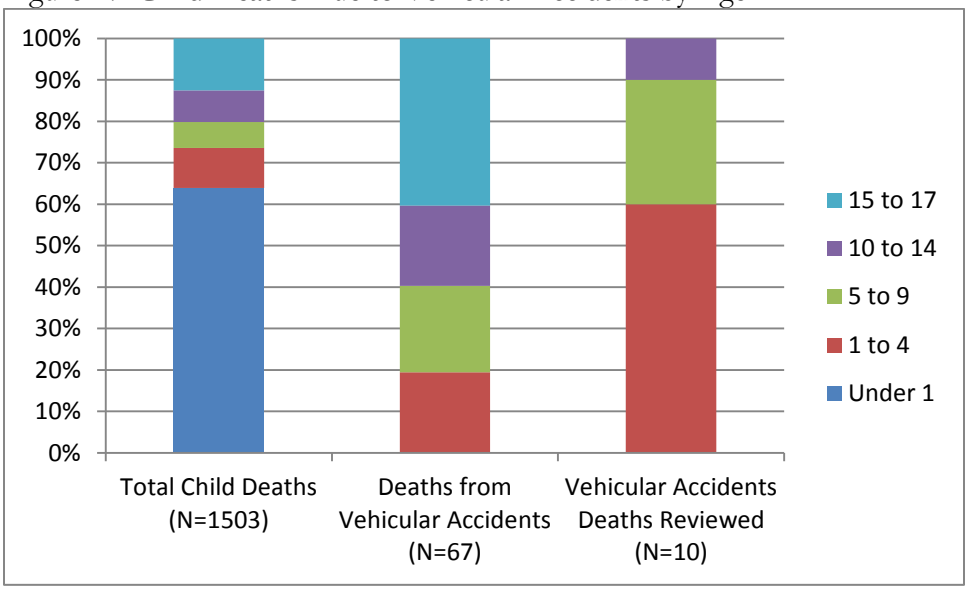
[22] Child Trends. (2014). *Distracted driving*. Retrieved from www.childtrendsdatabank.org/?q=node/376.
[23] Insurance Institute for Highway Safety. (2014). *Fatality facts 2012: Teenagers.* Retrieved from http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 10 of the 163 deaths reviewed by the CDRTs (6%) were related to vehicular accidents.

- 60% of the reviewed deaths in this category were males.
- The majority of reviewed deaths related to vehicular accidents were 1 to 4 years old (60%), followed by 5 to 9 years old (30%) and 10 to 14 years old (10%) (see Figure 17).

Figure 17: Child Deaths Due to Vehicular Accidents by Age



Injuries

Definition

This category includes deaths due to all types of injuries not covered in other categories of death. These injuries may be intentionally inflicted upon a child by him/herself (suicide) or others (homicide), or may be unintentional (accidents). Child deaths due to injuries from fatal child maltreatment are included in this category.

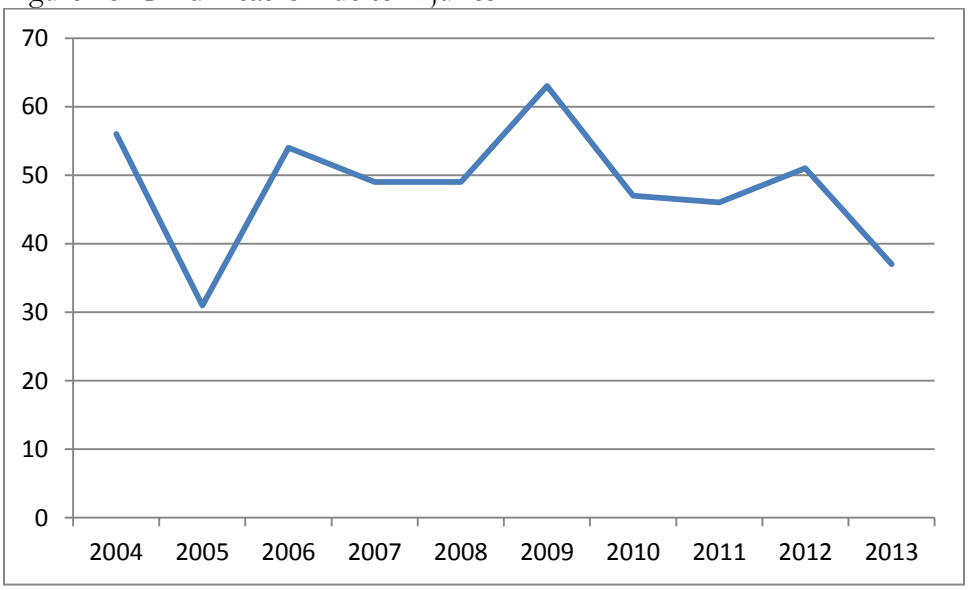
Background

Child maltreatment (including abuse and neglect) is one cause of death from injuries. In 2012, the National Child Abuse and Neglect Data System (NCANDS) reported a total of 1,640 fatalities from child maltreatment. The number of reported child fatalities due to child abuse and neglect has fluctuated during the past five years. Younger children are more vulnerable to death as the result of child abuse and neglect. Nearly three-quarters (70.3%) of all child fatalities were younger than 3 years, and in general, the child fatality rate decreased with age. Four-fifths (80.0%) of child fatalities were caused by one or more parents.[24] Of the children who died, 69.9% suffered neglect either exclusively or in combination with an additional maltreatment type and 44.3% suffered physical abuse either exclusively or in combination with another maltreatment type.[25]

Illinois Data – Total Child Deaths Reported to the CDRTs

The number of child deaths due to injuries fluctuates from year to year, with no clear increasing or decreasing trend (see Figure 18).

Figure 18: Child Deaths Due to Injuries



[24] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2012). *Child maltreatment, 2012*. Washington, DC: Government Printing Office. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf.
[25] Ibid.

In 2013, 37 of the 1,503 total child deaths reported to the CDRTs (2%) were related to injuries.

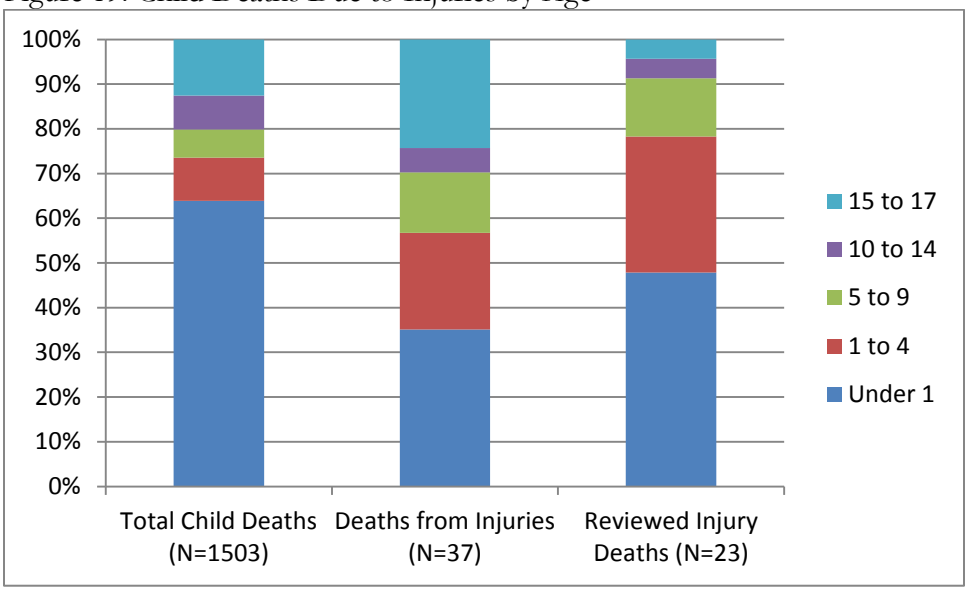
- The majority (84%) of the injury deaths were due to homicides, with the remaining due to accidents (14%) and suicides (3%).
- 76% of decedents from injuries in 2013 were male.
- Younger children were more vulnerable to death from injuries: 35% of injury deaths were among infants under the age of one, and an additional 22% were among children between the ages of 1 and 4. Children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 14%, 5%, and 24% of deaths due to injuries respectively.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 23 of the 163 deaths reviewed by the CDRTs (14%) were related to injuries.

- All reviewed injury deaths were due to homicides.
- 74% of the reviewed injury deaths were male.
- The vast majority (78%) of the reviewed cases involved young children 4 years and under (see Figure 19).

Figure 19: Child Deaths Due to Injuries by Age



Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Deaths (SUID)[26]

Definition

According to Center for Disease Control (CDC),[27] each year in the United States, about 4,000 infants die suddenly and unexpectedly. These deaths are called Sudden Unexpected Infant Deaths (SUID). Half of the SUID deaths are due to Sudden Infant Death Syndrome (SIDS), which is defined as the sudden death of an infant that cannot be explained after a thorough investigation is conducted that includes a complete autopsy, examination of the death scene, and review of the clinical history. Another type of SUID is unknown cause death, which refers to the sudden death of an infant that cannot be explained because a thorough investigation was not conducted and cause of death could not be determined. The third type of SUID is accidental suffocation and strangulation in bed, which has been included in the category of "suffocation" in the report.

Background

CDC launched an initiative in 2004 to improve the investigation and reporting of Sudden SUID. A pilot program of the SUID Case Registry (SUID-CR) began in Colorado, Georgia, Michigan, New Jersey, and New Mexico in 2009. It is designed to provide more detailed data about case investigation findings so that medical, environmental, and behavioral facts associated with SUID can be described in greater detail.

A decline in SIDS deaths has occurred since the 1990s largely because of the Back to Sleep Campaign (now called Safe to Sleep). However, one study suggests that since 1999, certain deaths previously classified as SIDS are now classified as accidental suffocation or unknown/unspecified cause, which may account for part of the recent decrease in SIDS rates.[28]

Exposure to secondhand smoke is a factor that increases the probability of SIDS. Since 2005, the percentage of children ages 0 to 6 living in a home where someone smoked regularly declined in all racial and income groups, while the disparities among racial and income groups remain unchanged. In 2010, the percentage of children ages 0 to 6 living in homes where someone smoked regularly was 6%, compared with 27% in 1994.[29]

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[26] In previous CDRT reports (2007-2008) SUID was an acronym for Sudden Unexplained Infant Deaths. According to the AAP and Center for Disease Control (CDC), the current SUID description is Sudden Unexpected Infant Deaths whether they can be explained or are unexplained.

[27] Center for Disease Control and Prevention. (2014). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome.* Retrieved from http://www.cdc.gov/sids/.

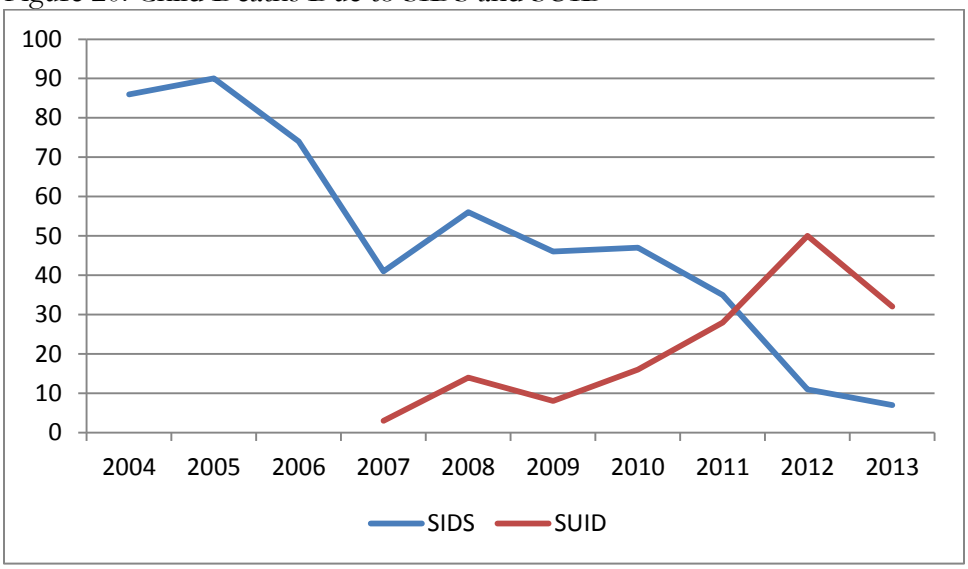
[28] Shapiro-Mendoza, C.K., Tomashek, K.M., Anderson, R.N., & Wingo, J. (2007). Recent national trends in sudden infant deaths: More evidence supporting a change in classification and reporting. *American Journal of Epidemiology*, *163,* 762-769.

[29] Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2014*. Washington, DC: U.S. Government Printing Office. Retrieved from http://childstats.gov.

Illinois Data – Total Child Deaths Reported to the CDRTs

Since the peak of 2005, SIDS has generally experienced a sharp decline, with the lowest number of SIDS deaths in 2013 (see Figure 20). Infant deaths from SUID were added as a category in 2007, and child deaths due to unknown causes have increased from 11 in 2007 to 50 in 2012. However, the SUID also experienced a sharp decline in 2013.

Figure 20: Child Deaths Due to SIDS and SUID



In 2013, 7 of the 1,503 total child deaths reported to the CDRTs (<1%) were related to SIDS, and 32 deaths (2%) were categorized as SUID.

- Less boys (43%) than girls had deaths related to SIDS, but more boys (66%) than girls had deaths related to SUID.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, only 1 of the 163 deaths reviewed by the CDRTs was related to SIDS and 6 were from SUID.

- The one SIDS death reviewed by the CDRTs was a girl, and 83% of the SUID causes of death cases reviewed by the CDRTs were boys.

Drowning

Definition
Drowning deaths occur from asphyxiation due to submersion in a liquid.

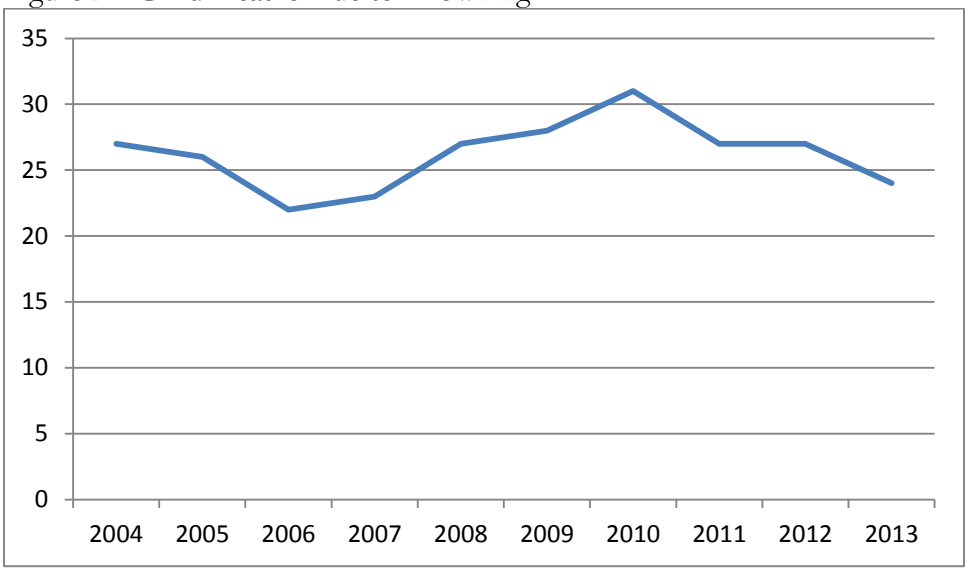
Background
In 2012, 851 children ages 17 and under died as a result of accidental drowning in the United States. Children ages 4 and under accounted for 54% of these deaths.[30]

The majority of infant drowning deaths happen in bathtubs or large buckets. Swimming pools are the most common site for a drowning to occur among children between the ages of 1 and 4 years, and about 3/4 of pool submersion deaths occur at a home. African American children ages 5 to 14 years old have a drowning rate 2.7 times greater than that of white children.[31]

Illinois Data – Total Child Deaths Reported to the CDRTs

Since 2004, there have been between 22 and 31 deaths from drowning per year (see Figure 21).

Figure 21: Child Deaths Due to Drowning



[30] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.
[31] Safe Kids Worldwide. (2014). *Swimming and Boating Safety Fact Sheet 2013*. Retrieved from http://www.safekids.org/fact-sheet/swimming-and-boating-safety-fact-sheet-pdf.

In 2013, 24 of the 1,503 total child deaths reported to the CDRTs (2%) were related to drowning.

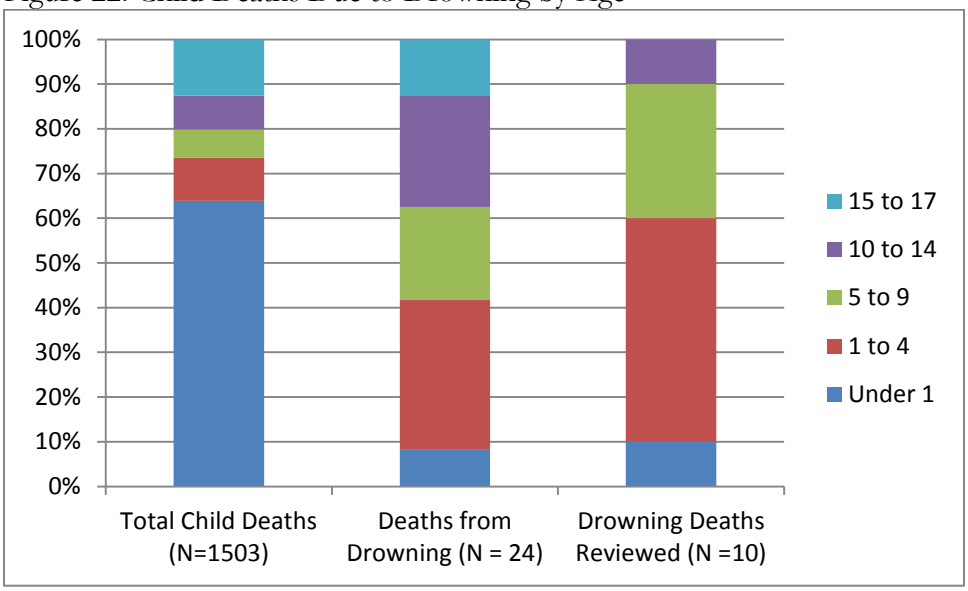
- Most of the drowning deaths were accidental (88%), and the rest were homicide (8%) and undetermined (4%).
- More boys (83%) died from drowning than girls.
- Children aged 1 to 4 years old, 5 to 9 years old, and10 to 14 years old accounted for 33%, 21%, and 25% of deaths due to drowning respectively. Children under age 1 (8%) and 15 to 17 (13%) had a comparatively smaller proportion (See Figure 22).

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 10 of the 163 reviewed deaths (6%) were related to drowning.

- Most (90%) of the reviewed drowning deaths were due to accidental causes.
- Most (90%) of the reviewed drowning deaths were male.
- Most (80%) of the reviewed deaths related to drowning occurred among children 1 to 9 years old (See Figure 22).

Figure 22: Child Deaths Due to Drowning by Age



Fire

Definition

This category includes deaths that are the result of burns and smoke inhalation.

Background

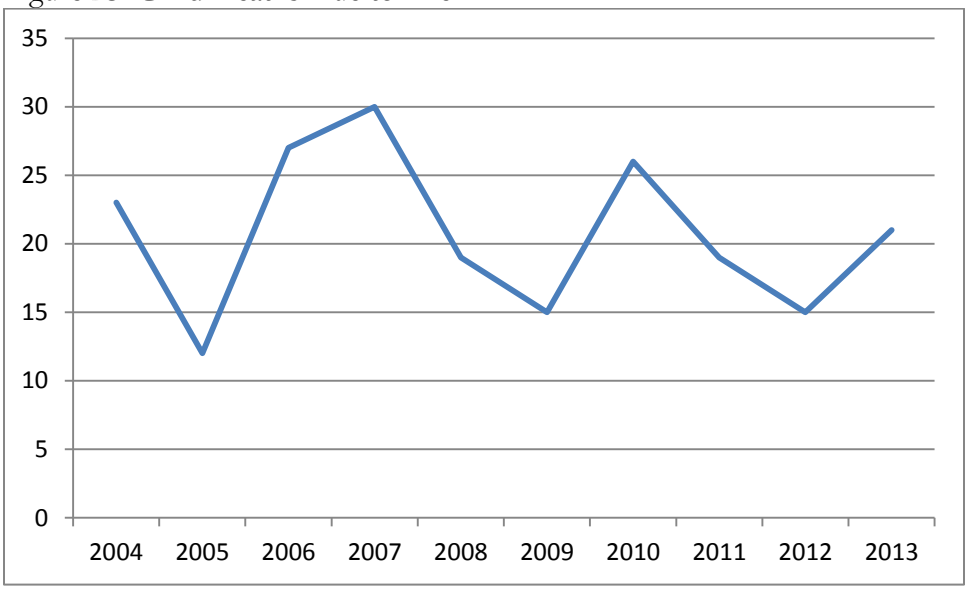
In the United States, fire and burns were the cause of 291 deaths among children between 0 and 17 years in 2012.[32] Forty eight percent of fire deaths occurred in children 4 and under. Death rates per million among children 14 and under has decreased 41% from 2001-2010.[33]

Home fires account for 85% of all fire-related fatalities in 2011. Working smoke alarms reduce the chances of dying in a fire by nearly 50%.[34]

Illinois Data – Total Child Deaths Reported to the CDRTs

Child deaths from fire have fluctuated over the decade from 2004 to 2013, typically falling between 15 and 25 (see Figure 23).

Figure 23: Child Deaths Due to Fire



[32] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

[33] U. S. Fire Administration, (2014). Child Fire Death Rates and Relative Risk (2001-2010) Retrieved from http://www.usfa.fema.gov/statistics/estimates/trend_child.shtm.

[34] Safe Kids Worldwide. (2014). *Fire safety.* Retrieved from http://www.safekids.org/fire.

In 2013, 21 of the 1,503 total child deaths reported to the CDRTs (1%) were related to fires.

- The majority of deaths (57%) attributable to fire were accidental, 24% were homicides, and 19% were undetermined.
- There were slightly more boys (52%) that died from fire.
- Children under 5 years old accounted for 15% of deaths due to fire, and children 5 to 9 years old, 10 to 14 years old, and 15 to 17 years old accounted for 33%, 33%, and 19% of deaths due to fire respectively.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, none of the 163 deaths reviewed by CDRTs were related to fires.

Poisoning/Overdose

Definition

Deaths due to poisoning result from the ingestion of a harmful substance, while deaths from overdose include the ingestion (either intentional or unintentional) of lethal amounts of harmful and non-harmful chemical substances (e.g., medicine, drugs).

Background

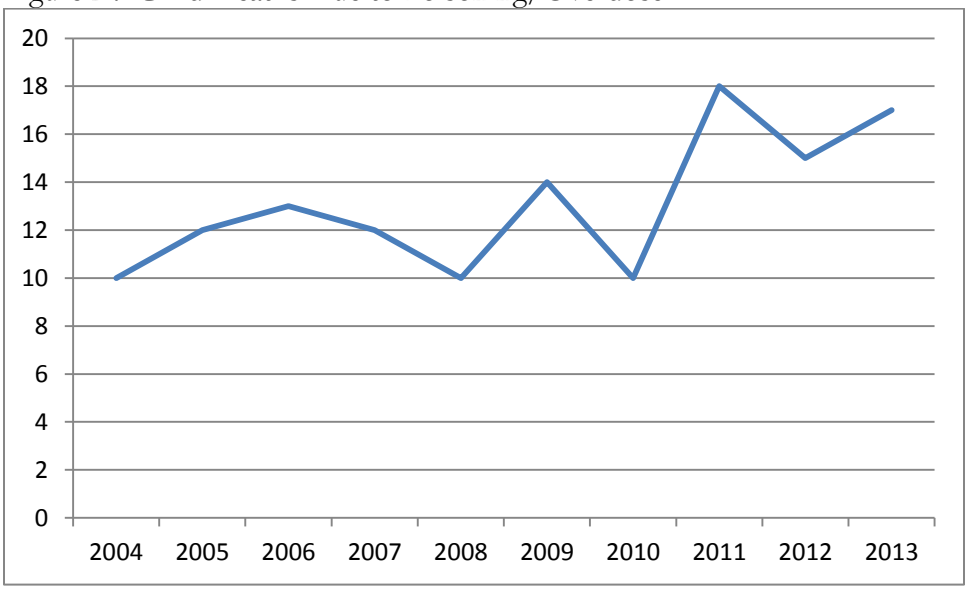
In 2012, 381 children under 18 years died of poisoning in the United States.[35] The majority of these deaths occurred in children 15 to 17 years of age (55%). The age group with the second most frequent number of deaths by poisoning was children under 4 (26%), with children between 4 and 15 accounting for 19% of poisoning deaths.

Each year 60,000 U.S. children are treated in emergency departments for unintentional medication exposure or overdose. For children under five, 95% of these visits are caused by accidental ingestion of medications, and 5% are dosing errors.[36] The high poisoning death rate among older teenagers is due to overdose of illegal or legal drugs, either accidentally or intentionally as a method of suicide.

Illinois Data – Total Child Deaths Reported to the CDRTs

Between 10 and 18 children died from poisoning per year since 2004, and the poisoning deaths in 2013 is approaching the record high in the decades from 2004 to 2013 (see Figure 24).

Figure 24: Child Deaths Due to Poisoning/Overdose



[35] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

[36] Baker JM, Mickalide, AD. (2012). *Safe storage, safe dosing, safe kids: a report to the nation on fare medication.* Washington, DC: Safe Kids Worldwide.

In 2013, 17 of the 1,503 total child deaths reported to the CDRTs (1%) were related to poisonings or overdoses.

- 12 of the 17 deaths (71%) were determined to be accidents, 1 death was a homicide, 3 were suicides, and 1 was undetermined.
- Girls (53%) were slightly more likely to die from poisoning or overdose than boys.
- 15 of the 17 deaths (88%) were children 15 to 17 years old, one death was 1 to 4 years old, and one death was 10 to 14 years old.

Illinois Data – Deaths Reviewed by the CDRTs

In 2013, 1 of the 163 deaths reviewed by the CDRTs was related to poisoning/overdose.

- The reviewed death was a female.
- The reviewed death was a child of 15 to 17 years old.

Uncommon Death Categories: Scalding Burn, Sudden Unexplained Child Death (SUCD), and Other

There are several less common categories of deaths. Each accounts for less than 1% of child deaths per year.

Scalding Burn

There was no scalding burn death in 2013.

Sudden Unexplained Child Death (SUCD)

There was 1 SUCD in 2013 and was not reviewed.

Other

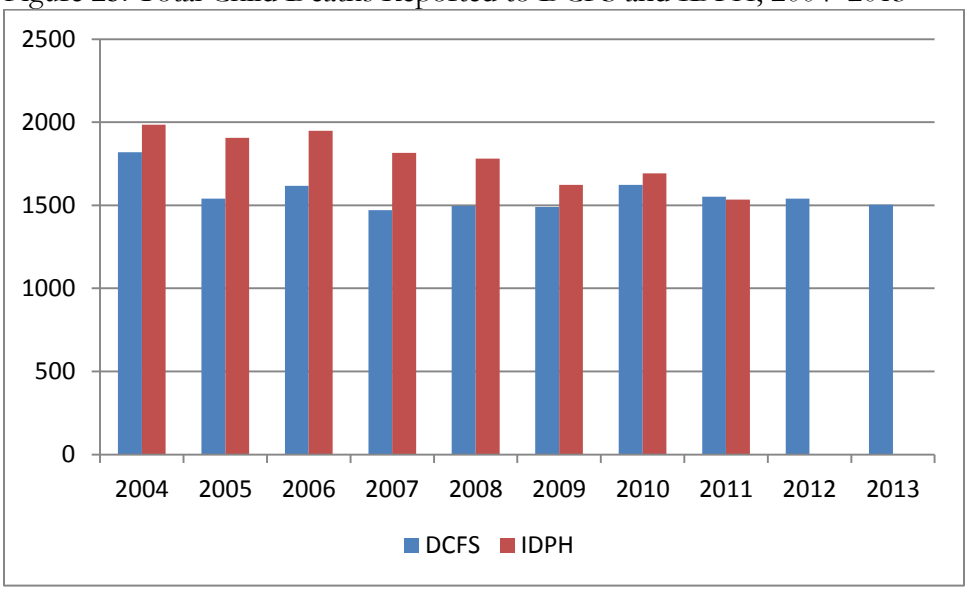
As implied by this name, the deaths that do not fit in the other categories are included in this category (including but not limited to hypothermia, heat stroke, hyperthermia, dehydration, air embolism, and malnourishment). In 2013, 4 deaths fell in this category and 2 of them were reviewed.

Chapter 5: Trends in Illinois Child Deaths

The Illinois CDRT database contains information on child deaths since 2000, which allows for an analysis of the trends in Illinois child deaths over time. Since 2012, the deaths reported to IDPH and DCFS have been consolidated and there is only one number for child death reports.

The total number of deaths the CDRTs have tracked has been relatively stable since 2005 (between 1,470 and 1,622). This is partially due to more accurately capturing the total number of child deaths. The total number of child deaths (reported by IDPH before 2012) in Illinois has been generally decreasing from 1,985 in 2004 to 1,503 in 2013 (see Figure 25).

Figure 25: Total Child Deaths Reported to DCFS and IDPH, 2004–2013

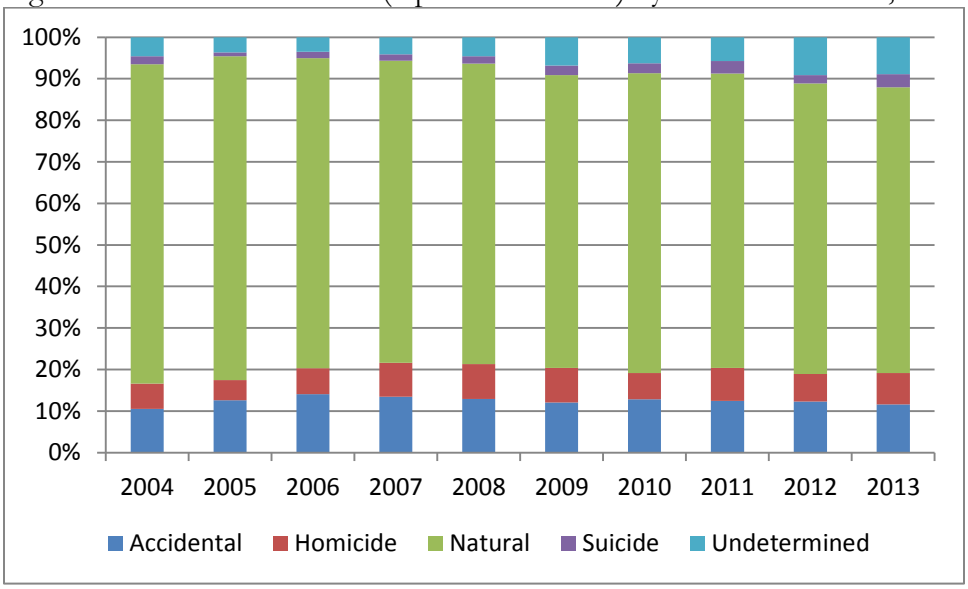


The total child deaths reported to the Child Death Review Team Unit from 2004 to 2013 is broken down by age group in Figure 26. For each year, the number of children in each age group is translated into its percentage of the total deaths that year. The percentages for each group are stacked on top of one another, so that the sum for each year is 100%. This type of graph allows us to compare the percentages of each category across multiple years, so that we can determine, for example, if the percentage of infant deaths is increasing, decreasing, or staying the same. As Figure 26 shows, the percentage of total deaths in each age group is generally stable over the 10 year period: infants under 1 year comprise 58-69% of all child deaths, children between 1 and 4 years comprise 9-17%, children between 5 and 9 years add another 4-6%, those between 10 and 14 years represent 6-9%, and youth between 15 and 17 years are the final 11-15%.

Figure 26: Total Child Deaths (reported to DCFS) by Age Group, 2004–2013

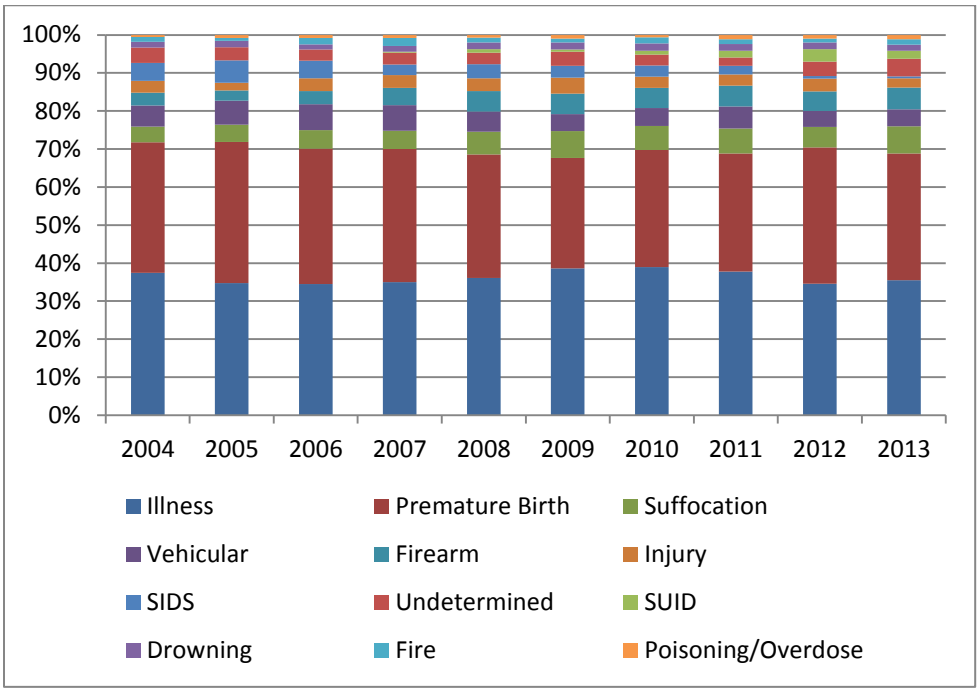
An analysis of the manner of child deaths over time reveals small fluctuations in proportion of deaths related to each: 10-14% accidental, 5-8% homicide, 69-78% natural, 1-3% suicide, and 4-9% undetermined (see Figure 27).

Figure 27: Total Child Deaths (reported to DCFS) by Manner of Death, 2004–2013



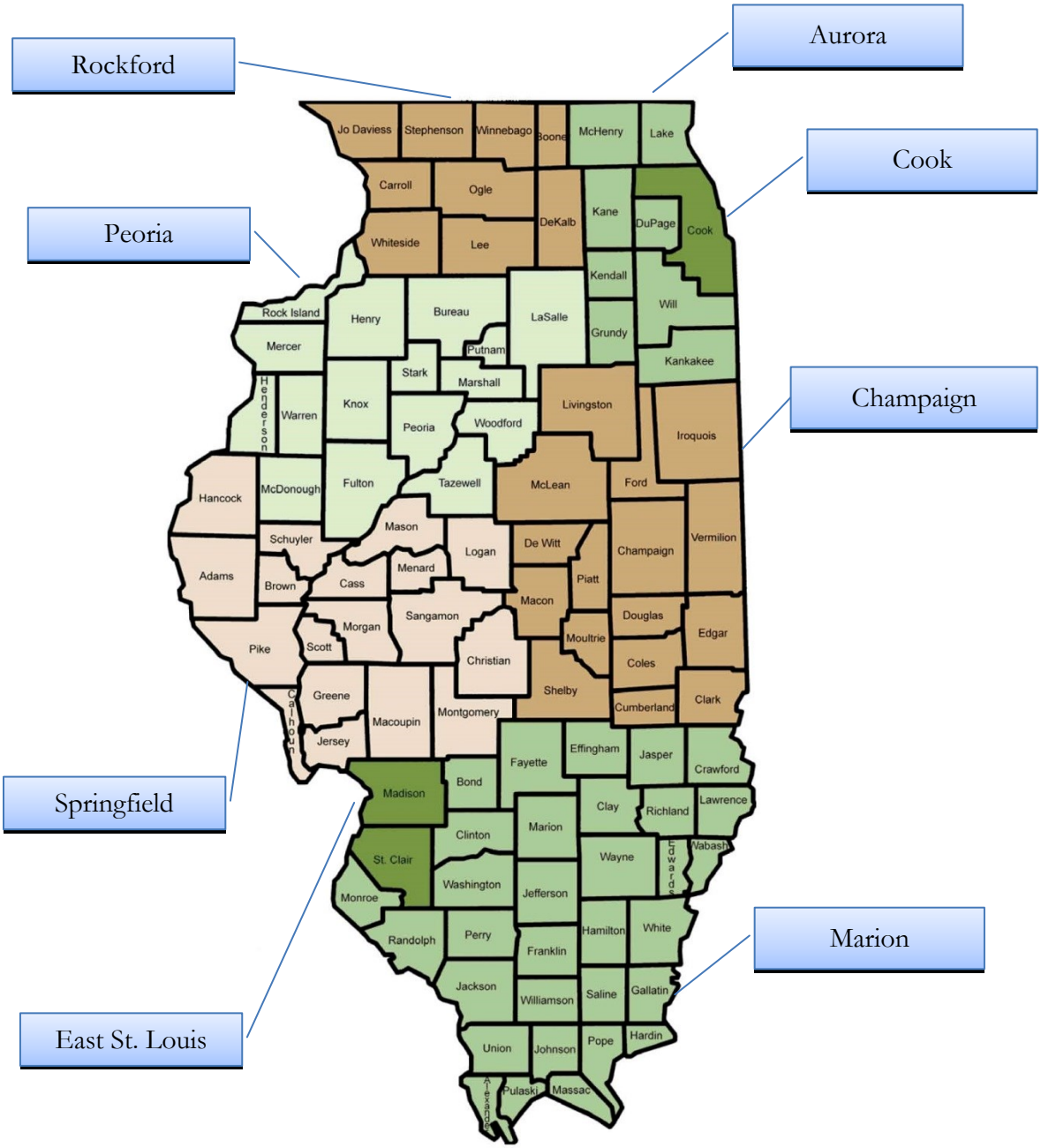
A similar analysis was done for category of death (see Figure 28). The overall percentage of child deaths related to each category of death remained relatively stable across the time periods. In order to see changes within category, please refer to charts for specific categories in Chapter 4.

Figure 28: Total Child Deaths (reported to DCFS) by Category, 2004–2013[37]



[37] Notice that 4 rare categories are not included in this chart: pending, other, scalding burn, and SUCD.

Appendix A – Child Death Review Team Regional Map



Appendix B – List of CDRTs by Region

Aurora
Myra West, PsyD, **Chairperson**
Mitra Kalelkar, MD, **Vice-Chairperson**
Cathleen De La Mar
Patrick Dempsey
Jody Gleason
Mary E. Jones, MD, MPH
Kathryn Juzwin, PsyD
Dawn Livorsi, LCSW
Gwendolyn Messer, MD
Loren Richardson Carrera
Glendean Sisk, RN, BSN, CRADC, MPH
Dan Thomas
DCFS Staff – Larissa Rico

Champaign
Lawrence Solava, **Chairperson**
Donald F. Davison, Jr. MD, **Vice-Chairperson**
Kathleen Carney Buetow, MD
Kim Cessna
Jackie Dever
Kimberly S. Fitton
Lise Jankowski, RN
Patricia Metzler, RN, TNS, SANE-A & P
Alex F. Meyer, Sgt.
Susan Elaine Minyard, PhD
Duane Northrup
Judy Osgood, PhD
James Owens
Cindy Patterson
Jamie Perry
Rush Record
Julie Runyon
Bryant Seraphin, Lt.
DCFS Staff – Maria Miller

Cook Team A
Anne Devaud, PsyD, **Chairperson**
Joan M. Pernecke, Chief, **Vice-Chairperson**
Ponni Arunkumar, MD
Barry Bennett, LCSW, ACSW
Kristen Bilka, MMS, PA-C
John Brassil
Danielle Butts
Anne Chambers, Sgt.
Felicia Clark
Stephanie Cornette, PC, PsyD
Kristin Escobar-Alvarenga, MD
Amanda Fingarson, DO
Jan Fowler, RN, MA
Jill Glick, MD
Gabriela Lagos, LCPC
Eileen Payonk, Special Agent
Dr. Nathaniel Robinson Jr., Ed.D
Norell Rosado, MD
Adrienne Segovia, MD
Kimberly Souder
Kelley Thornton
Dion Trotter
Kavita Vankineni, MD
Latanja Watkins, MD
Yvonne M. Zehr, Chief Deputy
Virginia Zic-Schlomas, Sgt.
DCFS Staff - Ann Marakis

Cook Team B

Diane Scruggs, **Chairperson**
Kathy Grzelak, MA, LCPC, **Vice-Chairperson**
Sweety Agrawal, PsyD
James R. Burton
George Canellis
Karla M. Chaplin, Sgt.
Suzanne R. Dakil, MD
Eric Eason, MD
Angela Evans, MPH, RN, BSN
Lindsay Forrey, LCSW
Marjorie Fujara, MD, FAAP
Mary Joly Stein
Michele Lorand, MD
Frank J. Marek
Denika Means, MD
Theresa Olson
Evelyn Polk-Green, M.S.Ed.
Veena Ramaiah, MD
Benjamin Soriano, MD
Sandy Stavropoulos
Cindy Weatherspoon
Valencia Williams, PsyD
Eimad Zakariya, MD
DCFS Staff - James Robinson

East St. Louis

Daniel Cuneo, PhD, **Chairperson**
Alison Hebrank, **Vice-Chairperson**
David Bivens, Sgt.
Cathy Daesch, ATR-BC, LCPC, ICDVP
Joseph Edwards, Chief
Amanda Fischer
Beth Horner, PhD
Carolyn Hubler
Gilda Johnson, Det.
Francis Jones, RN
David C. Norman, MD
Carole A. Presson, Lt.
Lindsey Reichert
Lynn Shelton, RN
Paula E. Wills
DCFS Staff – Valda Haywood

Marion

Chad Brown, Sgt., **Chairperson**
Mary Louise Cashel, **Vice-Chairperson**
Leah Brown
Tambra Cain
Jessica Cullum
Scott Deming, Sgt.
Connie Edgar
Michael S. O'Leary, Lt.
Jamie Penrod
Melissa Presser
Linda Reiss
Kathy Swafford, MD
Steve Webb, PhD
Sheryl L. Woodham, MSW, LCSW
DCFS Staff – Don Rose

Peoria

Ruth Lane, **Chairperson**
Judy Guenseth, **Vice-Chairperson**
Paul Bauer
America Bunker, RN
Jerry Brady
Susan Bordenave-Bishop, MD
Gregg M. Cavanaugh, M/Sgt.
Stefanie Clarke, BSN, RN, CPEN
Cindy Fisher
Brian Gustafson, RN
Emily McDonnell, RN
Marcy O'Brien, Det.
Channing Petrak, MD
Juli Smith, MSW
Mark Thomas
Michele Verda, PhD
DCFS Staff - Jim Marmion

Springfield

John C. Milhiser, **Chairperson**
Cinda Edwards, **Vice-Chairperson**
Careyana Brenham, MD
Myto Duong, MD
Shannon Fehrholz
Roy Harley
John Hayes, Det.
Clairice Hetzler
Shirley Johnson
Stephanie Lake, RN
Lorinda Lamken
Mary Frisk Loken, PhD
Nathaniel Patterson, MD
Jim Stone
Timothy Wilkins, Special Agent
John Yard, Special Agent
DCFS Staff - Gayle Hopper

Rockford

Joanna Deuth, **Chairperson**
Rebecca Hooks, **Vice-Chairperson**
Pamela A. Borchardt
Raymond Davis, Jr., MD
David Glessner
Lynn M. Grover
Leah Hantke, RNC, MS, WHNP
Marilyn Hite Ross
Julia Marynus, RN, BA
Dennis Miller
Holly Peifer
Pam VanderVinne, RN/CMC
Dave Watson
Rebecca Wigget
DCFS Staff - Angela Harris

Appendix C – Illinois Child Deaths by County

County	2005 Deaths		2006 Deaths		2007 Deaths		2008 Deaths		2009 Deaths		2010 Deaths		2011 Deaths		2012 Deaths	2013 Deaths
	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH	DCFS	IDPH*	DCFS	IDPH*	DCFS	IDPH*	CDRTs**	CDRTs**
Adams	0	6	1	8	8	11	1	10	6	5	6	5	4	3	9	5
Alexander	0	0	0	1	0	1	0	1	1	1	0	2	0	0	1	0
Bond	1	1	0	0	0	0	1	1	0	0	0	1	2	2	4	1
Boone	0	3	0	0	0	0	0	3	3	3	1	1	4	2	3	0
Brown	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1
Bureau	4	4	2	4	2	2	1	2	5	5	6	5	1	1	2	1
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0	1	1	0	0	0	1	1	1	2	2	0	0	1	0
Cass	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0
Champaign	52	53	32	47	3	39	21	36	42	36	36	33	43	37	29	49
Christian	9	10	2	2	0	0	3	4	4	4	4	3	3	2	2	1
Clark	1	1	1	1	0	0	1	1	0	0	0	1	2	2	1	3
Clay	0	0	0	0	0	0	0	1	0	0	1	1	0	0	1	1
Clinton	0	2	0	3	0	3	3	4	1	1	3	3	2	1	1	3
Coles	0	6	0	8	0	3	0	4	3	5	5	2	5	6	4	4
Cook	878	1,116	1,014	1,141	926	1,066	908	1,010	768	832	887	920	857	824	857	775
Crawford	0	0	0	1	0	1	1	1	0	0	2	1	2	1	4	4
Cumberland	0	2	1	1	0	0	3	2	2	3	2	2	0	0	1	0
DeKalb	2	4	1	14	4	5	3	3	5	3	4	3	5	5	4	9
Dewitt	0	1	0	2	0	1	0	0	2	2	0	0	1	1	0	0
Douglas	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	0
Dupage	112	116	93	95	97	99	76	81	65	62	89	76	73	68	66	70
Edgar	1	1	2	3	0	1	1	2	0	0	0	0	1	1	1	1
Edwards	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Effingham	1	6	3	4	0	7	5	6	1	1	0	1	8	7	2	7
Fayette	1	1	0	1	0	1	0	0	0	0	1	0	1	1	0	2
Ford	2	2	1	1	1	1	3	3	1	0	1	1	0	0	1	2
Franklin	3	0	1	0	3	3	3	3	4	4	5	3	2	1	0	2
Fulton	0	0	2	2	5	5	0	0	3	4	4	4	0	0	3	0
Gallatin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Greene	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0
Grundy	1	3	2	3	0	5	3	4	3	4	5	5	3	2	3	2
Hamilton	0	0	3	3	1	1	3	3	0	0	1	1	1	1	1	2
Hancock	0	0	0	1	0	0	0	2	2	1	0	0	1	1	0	1
Hardin	1	1	0	0	0	1	0	0	0	0	2	2	1	2	1	1
Henderson	0	0	0	3	0	0	0	0	0	1	0	0	0	0	0	0
Henry	3	3	1	1	4	4	2	2	2	3	4	4	4	2	2	3
Iroquois	1	1	0	0	0	2	0	1	0	0	3	3	1	1	1	1
Jackson	0	8	0	4	3	4	8	8	9	8	4	5	8	6	16	2
Jasper	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0
Jefferson	0	1	1	2	0	3	1	4	1	1	9	9	7	6	2	6
Jersey	0	1	0	1	1	3	0	2	0	0	1	2	2	3	4	2

Jo Daviess	2	2	3	3	0	1	0	0	0	0	0	0	4	4	0	1
Johnson	0	0	0	1	1	0	0	0	0	2	0	3	0	3	2	0
Kane	50	56	44	61	37	46	59	57	55	53	44	41	45	42	42	42
Kankakee	15	15	14	14	9	9	8	13	5	5	8	8	8	8	12	10
Kendall	3	3	1	1	6	6	6	6	2	2	1	1	1	1	2	3
Knox	4	4	5	5	3	3	4	4	2	2	7	8	10	10	3	4
Lake	17	34	35	58	17	37	26	38	34	47	31	47	35	40	33	37
LaSalle	0	8	0	9	0	8	0	9	7	7	8	9	9	8	11	8
Lawrence	1	1	1	1	0	0	1	3	1	1	6	4	4	2	1	2
Lee	2	1	0	1	0	2	0	1	3	5	1	1	2	2	2	3
Livingston	0	3	0	4	0	5	2	5	2	2	3	3	5	2	3	0
Logan	0	0	0	0	0	0	7	8	6	5	0	0	2	2	3	3
Macon	14	14	18	18	15	16	18	21	15	15	11	10	13	13	7	4
Macoupin	0	1	0	1	0	1	0	0	2	2	2	3	0	0	0	5
Madison	6	22	8	20	14	19	21	25	16	20	15	13	13	11	8	12
Marion	2	7	2	2	4	4	4	3	3	6	3	9	5	9	2	5
Marshall	0	0	0	1	0	0	0	0	3	2	2	1	0	0	0	0
Mason	0	1	0	3	0	0	0	0	0	0	2	1	0	0	0	3
Massac	1	2	1	1	1	1	1	1	4	2	0	0	0	0	2	1
McDonough	0	4	0	2	0	0	0	1	1	2	2	2	1	1	1	2
McHenry	15	15	9	10	23	24	14	19	11	11	7	6	11	9	12	17
McLean	14	18	12	16	11	10	14	14	5	6	9	10	13	12	9	12
Menard	0	3	0	0	0	0	0	1	1	1	1	1	0	0	0	0
Mercer	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2	6
Monroe	1	1	1	1	1	1	0	0	2	2	0	1	1	1	1	1
Montgomery	1	3	2	2	3	3	0	1	1	0	3	3	3	2	1	0
Morgan	2	2	0	1	1	1	0	2	1	1	2	2	0	1	2	3
Moultrie	2	2	1	1	0	0	3	3	0	0	1	1	4	4	1	0
Ogle	3	4	2	2	3	3	4	4	3	3	2	1	1	1	0	0
Peoria	86	87	92	97	51	77	49	86	76	93	81	80	76	75	109	72
Perry	0	0	2	3	1	4	2	3	0	0	4	4	0	0	1	3
Piatt	0	0	0	0	0	1	0	2	0	0	0	0	1	1	1	0
Pike	0	0	0	2	0	0	0	0	0	0	2	2	0	0	0	0
Pope	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0
Pulaski	0	0	0	0	0	0	0	0	2	2	0	0	0	0	0	0
Putnam	0	0	0	0	0	0	0	0	2	2	0	0	0	0	0	0
Randolph	1	2	0	0	1	4	0	0	1	1	1	1	1	1	6	7
Richland	4	4	1	3	0	0	1	3	1	1	1	1	2	2	1	1
Rock Island	17	17	4	4	19	19	12	12	18	17	12	9	12	11	11	9
Saline	1	1	3	3	2	2	2	2	4	2	4	3	1	1	3	0
Sangamon	57	58	45	52	48	54	32	46	51	48	46	43	38	46	33	46
Schuyler	0	0	0	3	0	0	0	0	0	0	4	0	6	0	1	1
Scott	0	0	0	0	0	1	0	1	0	2	0	0	0	0	0	2
Shelby	0	0	3	3	1	1	3	3	2	5	1	2	0	0	0	2
Stark	22	29	23	35	14	29	7	26	26	28	18	16	18	15	21	31
St. Clair	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stephenson	5	5	1	2	3	4	4	5	4	4	5	4	2	2	1	2
Tazewell	9	10	6	9	3	5	4	7	2	2	2	3	3	2	3	2
Union	0	1	0	0	2	2	0	0	2	2	3	3	1	1	1	2

Vermillion	8	9	3	4	9	12	1	6	13	14	7	6	8	6	11	10
Wabash	0	2	0	0	0	1	0	2	3	2	0	0	0	0	1	0
Warren	0	1	0	1	0	0	0	1	0	1	1	1	1	1	1	1
Washington	0	1	0	1	0	1	0	0	0	0	2	2	1	1	0	1
Wayne	0	0	1	1	1	2	0	1	1	1	1	1	1	1	2	1
White	0	0	0	0	0	0	0	0	1	1	1	1	1	1	1	0
Whiteside	1	5	1	4	0	6	0	3	7	6	3	5	4	3	1	4
Will	35	36	40	41	42	43	42	38	44	47	38	35	28	26	33	34
Williamson	8	1	6	2	4	9	8	9	6	5	5	5	10	9	6	6
Winnebago	54	57	61	75	58	65	71	78	59	48	61	49	51	43	40	36
Woodford	1	1	1	2	0	0	1	1	1	2	2	2	3	3	1	4
Unknown	3	0	0	0	0	0	0	0	18	0	1	0	0	1	0	0
Out of State	–	–	1	0	4	0	13	0	27	81	53	117	46	97	47	81
Out of country	–	–	–	–	–	–	–	–	–	–	–	–	–	–	9	0
Total	1,540	1,906	1,617	1,948	1,470	1,815	1,495	1780	1490	1622	1622	1692	1551	1535	1540	1503

***Death numbers for IDPH are for facility of death**

****Death numbers for DCFS and IDPH have been consolidated since 2012**